2013

The Methodological Challenges of Conducting Research on Elderly Chinese Immigrants in Residential Settings

Jessica Thomas

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The Methodological Challenges of Conducting Research on Elderly Chinese Immigrants in Residential Settings

**Degree Type**
Open Access Senior Honors Thesis

**Department**
Health Sciences

**First Advisor**
Richard L. Douglass

**Keywords**
Chinese Immigrants, Elderly, Research Methods, Residential Setting

**Subject Categories**
Medicine and Health Sciences

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THE METHODOLOGICAL CHALLENGES OF CONDUCTING RESEARCH ON ELDERLY CHINESE IMMIGRANTS IN RESIDENTIAL SETTINGS

By

Jessica Thomas

A Senior Thesis Submitted to the

Eastern Michigan University

Honors College

in Partial Fulfillment of the Requirements for Graduation

with Honors in the School of Health Sciences

Approved at Ypsilanti, Michigan, on this date April 15, 2013
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Introduction

Several individuals in the United States have problems accessing the health care system due to transportation issues, limited or no health insurance coverage, financial hardships, or a lack of familiarity with the public resources that are available to them—just to name a few. Consider being an immigrant to this country, however, and having all of those disadvantages thrust upon you before even entering the health care system, while also having to face the obvious language barrier and cultural divergences. On the other hand, consider the physician who is expected to uphold the principal-agent relationship with his/her patients by making the same decisions for a patient as a fully informed patient would do for him or herself; there would be difficulty in understanding what the patient would see as the "best" choice for his or herself because of their linguistic and cultural differences. In becoming aware of the health care obstacles of both an immigrant and physician, ponder on the fact that in 2006 there were 1.6 million foreign born from China in the United States, and that population has since grown (Terrazas & Devani). This information is important for a number of reasons but the most obvious is the health care disparities for this group and how they may unintentionally be going unaddressed.

Chinese immigrants are a rapidly growing population in the United States and many of those individuals that immigrated here years ago are approaching old age, therefore creating a greater demand in health care needs and services for their elders. However, in understanding the demand, a question of if there is an actual comprehension of how to address their needs comes into play. This issue came to my attention after observing a group of elderly, Chinese immigrants in an affordable housing community in Ann Arbor, Michigan, who had difficulty in accessing health care services in the community. My efforts in pointing out the health care needs of this group had very little progression due to the difficulty of building rapport, which is very
Important when entering any community, but also problematic when the parties speak different languages. My previous inclination to do a need assessment on this group was short-lived when I realized that the methodology would be too arduous to set up without a team who could both interpret and translate Mandarin and English. The language barrier was the obvious roadblock in receiving the answers I sought out, but there were other problems that were discovered as I observed this group further. The difficulties I came across while working with elderly Chinese immigrants led to the organization of this thesis, which is to review the quantity and quality of published research on elderly Chinese immigrants in residential settings. My thesis will also assess the research methods that are used for this type of research in terms of adequacy of methods and research strategies. In doing so, I hope to discover useful and appropriate research methodologies that are used when conducting research on elderly Chinese immigrants, so that similar methods can be applied in the future for other immigrant populations.

Uncertainty Leads to Exploration

As mentioned previously, my idea to create a need assessment on the health care needs of elderly Chinese immigrants was unfulfilled because of the language barrier and my lack of understanding of how to set up research methodologies. I thought that it would be appropriate to first find preceding published articles that were similar and included material on this population in residential settings so that I could build the foundation for my own endeavors. I used databases such as PubMed, Business Scholarly and Trade, CINAHL, and Google Search Engine to find examples of published articles on the subject. What I found in seeking more information was serendipitous however; I realized that there was an abundance of published research on elderly Chinese immigrants in the United States but there seemed to be little research on those immigrants living in residential settings. Most of the research found on Chinese in residential
settings was based on research done in Hong Kong, which would not be generalizable to the population in the United States. This realization made it even more difficult to create a methodology for my own need assessment and I assumed that if I was encountering this issue, many other researchers were probably coming across this problem with other immigrant populations as well. It became a possibility that this group may be underserved, under researched, and possibly not receiving the health care services that they need, especially for those living in nursing homes or assisted living settings. If this were to be the case, then many of the elderly Chinese immigrants could potentially wind up undiagnosed, misdiagnosed, or diagnosed too late in situations where primary prevention could have been sought instead of tertiary treatment. These assumptions are the reasons for research methodology in the first place.

Without having the correct methodology it is nearly impossible to communicate the needs of a group because there is little to no basis to learn; there are only questions that go unanswered.

One of the main difficulties with conducting research on immigrants is the lack of cultural competence about a particular group; going in blind could lead to errors in the very beginning of the research process and could without doubt wind up with skewed results. Research is not simply about producing results, it is making sure that the results that are produced are actually valid and representative of the group one is observing. If elderly Chinese immigrants have an array of literature with faulty research methods, then health care providers and the entire health care system will not be able to serve this population properly. This is why having knowledge of the quantity and quality of research on elderly Chinese immigrants is important. Knowing thy data is fundamental; research is obtained for results to turn into actions, otherwise there is no reason to seek it. If the answers we obtain are untenable we are not improving the health of a population, we are missing the actual information that could save the
lives of many, heal the chronic diseases of thousands, and overlooking the groundbreaking results that could have surfaced if done correctly.

Before continuing, it is important to understand what are considered residential settings in this paper. A residential setting can be described as any place to live where an individual can be provided with different services and supports and also maintain some level of independence. These types of places could be considered a nursing home, assisted living, independent living or group homes. Living arrangements are very important as we age because our needs begin to change; therefore it’s interesting that there is a lack of information on elderly Chinese immigrants and their living situations.

While reviewing the literature I found it necessary to understand some of the views Chinese Americans may have concerning long-term care. Throughout this thesis I will mention how the values and customs Chinese immigrants follow have an impact on their use of services, especially in nursing homes. Without having a level of competence on their philosophies of the subject it is difficult to interpret why there is a lack of data in the first place. Is the lack of data due to researchers not understanding how to set up the research methodology or are there customs or limitations that discourage or sway elderly Chinese immigrants from entering these settings in the first place? These questions are fundamental to developing appropriate research methods in the future for this group and other immigrant groups alike.

In Chinese culture old age is seen as a very important stage in life where wisdom is shared and relationships are built, especially among the adult children of elderly Chinese. Smith and Hung (2012) stated in their article that Confucianism is a major philosophy that affects Chinese behavior and social interaction and centers on loyalty, self-respect, benevolence, and
face-saving. Face-saving, as mentioned by Smith and Hung (2012), is simply the idea of keeping the family name honorable and is derived from one of the most important concepts in Confucianism, filial piety. The concept of filial piety is simple, "younger family members are obligated to administer care for elderly family members", and if one does not follow this notion then the family member could be shunned. In fact, for a child to send his or her parent to a nursing home would be considered shameful to the family and in turn result in them being disowned all together by their kin. Smith and Hung (2012) place emphasis on how critical filial piety is when considering the Confucian perspective, as well as how it is "the backbone in the Chinese conception of family". One of the statements that stood out the most was one made by Chang and Schneider: "any individual not heeding Confucian philosophy by placing his/her parent into a nursing home, even if the parent is stricken with a debilitating disease such as Alzheimer's, is apt to find out they have contravened millennia-old tradition" (2010). If this practice is held true for Chinese immigrants, then the lack of research on elderly Chinese immigrants in residential settings, specifically those that are in nursing homes, could be contributed to the idea of filial piety.

Comparative Analysis Table

Considering that the information I found on elderly Chinese immigrants was very limited, I determined that it would be efficient to create a table outlining the type of study that was done, the sources of data collected; the method of analysis; location; rather or not Chinese language was used; and if the researcher made any reference to the dialect used. The latter is very important because there are a number of dialects – or a variety of a language that is differentiated from other types of the same language (i.e. grammar, vocabulary) – in the Chinese language. If the researcher does not classify the type of dialect, it leaves room to question if the information
obtained from the participant is actually valid because different dialects could have various meanings for specific words. Mull over the idea of having to participate in a study that is written in Cantonese and you speak and read in Mandarin. In situations such as that, the chance of the participant making up an answer would increase and the chance of the results of a study being accurate would decrease; this would not at all be beneficial to the researcher, the participant, or the health care system overall.

The table has a total of six published articles that were done on living arrangements, health care service use, and studies about those who live within residential settings or about Chinese perceptions of residential settings; most of them relate to the latter. The table overall serves as an illustration to the comparative analysis I did of the published research articles I found within the databases, as the details are a little more complex in this text but the visual appears simpler. I will discuss the articles in the same order at which they are listed in the table, offering a description of the article and the methodologies used. Due to limited space, the table has been separated for better visibility but is in the same order and can be read as if it is horizontally across in its original form.

<table>
<thead>
<tr>
<th></th>
<th>Type of Study</th>
<th>Location</th>
<th>Method of Collection</th>
<th>Method of Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Quantitative</td>
<td>USA</td>
<td>Secondary Analysis of PUMS</td>
<td>Correlational Regression Analysis</td>
</tr>
<tr>
<td>2</td>
<td>Qualitative</td>
<td>USA</td>
<td>Secondary Analysis of MDS Plus</td>
<td>Descriptive Statistics</td>
</tr>
<tr>
<td>3</td>
<td>Quantitative</td>
<td>New York Institutional</td>
<td>Interview</td>
<td>Correlational Regression Analysis</td>
</tr>
<tr>
<td>4</td>
<td>Qualitative</td>
<td>Boston, Chinatown Personal</td>
<td>Individual Interview/Focus Group</td>
<td>Descriptive Statistics/Content Analysis</td>
</tr>
<tr>
<td>5</td>
<td>Qualitative</td>
<td>Boston, Chinatown Personal</td>
<td>Survey: Self-administered &amp; Interview</td>
<td>Descriptive Statistics</td>
</tr>
<tr>
<td>6</td>
<td>Qualitative</td>
<td>Massachusetts Institutional</td>
<td>Follow-up Interview</td>
<td>Descriptive Interpretations</td>
</tr>
<tr>
<td>7</td>
<td>Pilot Study (Qualitative)</td>
<td>USA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Method of Study</th>
<th>Location</th>
<th>Was the Chinese Language Used?</th>
<th>Dialect (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Quantitative</td>
<td>USA</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Qualitative</td>
<td>USA</td>
<td>Yes</td>
<td>Yes, but not explained</td>
</tr>
<tr>
<td>3</td>
<td>Quantitative</td>
<td>New York Institutional</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Qualitative</td>
<td>Boston, Chinatown Personal</td>
<td>Yes</td>
<td>Cantonese, Mandarin, &amp; Taiwanese</td>
</tr>
<tr>
<td>5</td>
<td>Qualitative</td>
<td>Boston, Chinatown Personal</td>
<td>Yes</td>
<td>Cantonese</td>
</tr>
<tr>
<td>6</td>
<td>Qualitative</td>
<td>Massachusetts Institutional</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
In order to understand the chart thoroughly however, some terms should be clarified. In this particular comparative analysis, there are two types of studies done, which are known as quantitative studies and qualitative studies. Quantitative studies typically are used to look at cause and effect relationships, make predictions, and to test a hypothesis. They tend to be much larger, focus on specific variables, and aim to collect numbers and statistics in order to identify statistical relationships. Quantitative studies also tend to use precise measurements using supported data collection instruments in order to assist researchers in describing, predicting, and explaining the hypothesis they are testing. On the other hand, qualitative data is used to comprehend and decipher social relationships and the data collected tends to be used in the form of words and illustrations. Unlike quantitative studies, a qualitative study will not control for the environment and will collect data in the form of interviews, observations, or field notes. Other terms that come up in the text quite often are primary and secondary data collection/analysis. Primary data collection is collected by the investigator conducting the research and secondary data analysis is data collected by someone besides the user leading the research. In simpler terms, secondary data analysis typically is information that was obtained for reasons other than its original use, such as census data.

When discussing the analysis of data, the terms correlational/regression analysis, descriptive statistics, or content analysis may appear often. Correlational/regression analysis is used mostly in quantitative studies and basically looks at the strengths of relationships between two or more variables. For example, correlational/regression analysis may observe the relationship between elderly Chinese immigrant’s socioeconomic status and their likelihood of participating in research studies. Descriptive statistics is also used in quantitative studies and uses numerical descriptions to measure things as they are. That particular method of analyzing
data is convenient when looking at how many people participated in a program and the characteristics of those that participated in a certain program (e.g. coming up with an average or mean). Lastly, content analysis is the method of analyzing communication content such as published articles, magazines, or health records. Content analysis is good for revealing issues of concern, identifying underlying intentions, and/or describing behavioral responses. With having this brief understanding of the terms, it may be easier to comprehend the following articles as I describe the methodologies used and their purpose.

Comparative Analysis

*Kamo and Zhou (1994)*

Kamo and Zhou did a study on the living arrangements of Chinese and Japanese elders living in the United States using 1980 U.S. Census Data on 8,502 persons (1994). They concentrated on three theoretical frameworks which were modernization, cultural specificity, and assimilation with regards of exploring the effects of acculturation, economic feasibility, and demographic availability on elderly living arrangements. Kamo and Zhou believe that the three theories could be merged into an integrated model that explains family patterns of immigrants. Based on those theories they devised four hypotheses:

1) “Race/ethnicity affects elderly living arrangements. Elderly persons of Asian origin in the United States are more likely than their non-Hispanic White counterparts to live in extended family households.
2) The lower the level of acculturation, the higher the probability of an elderly person living in an extended family household.
3) The lower the level of economic feasibility, the greater the likelihood of an elderly person living in an extended family household.
4) Insufficient self-support for elderly persons and the availability of kin increase the likelihood of an elderly person living in an extended family household.” (Kamo and Zhou, 1994)
In order to test their hypotheses they assessed the allocation of living arrangements of Chinese and Japanese Americans who were age 65 and above. They used elderly non-Hispanic whites as a comparative sample, as they are the majority and serve as a category of reference. Following that, they discovered the consequences of several determinants of elderly persons’ living arrangements within each racial/ethnic group and gender group. A logistic regression model was used to approximate the chance of an elderly person residing in their ever-married children’s homes. For clarity, logistic regression analysis is a model that assesses the effect of several factors on a dichotomous (i.e. dividing into two parts) outcome by approximating the probability of the events occurrence (Anderson). In doing this, Kamo and Zhou assign acculturation, economic, and demographic factors as the independent variables (i.e. the variable that one has control over). The principal dependent variable, (i.e. variable being tested and measured) in this specific study, is whether an elderly person lives in an extended family household, which is significant to the idea of filial piety in Asian culture.

As stated in the table, Kamo and Zhou obtained data from the public use microdata sample (or PUMS) of the 1980 Census of Population and Housing. In order to attain a sample that incorporates those that are 65 and older with particular information on characteristics of household heads and co-residing individuals, their sampling took a number of detailed steps. To begin, they selected each person 65 years and older of either Chinese or Japanese origin, (n=2,814) and for the purpose of comparison, they selected a sample of non-Hispanic whites (n=3,092). The U.S. Census data did include other Asian ethnic groups in the data, such as Koreans, but Kamo and Zhou included these groups into their research because the percentage of those minorities was so small. During the sampling process they noticed that the majority of elderly persons that were Chinese and Japanese resided in California and Hawaii so they
oversampled in non-Hispanic whites in both of those states. Following that, they attached to each elderly person, supplementary information pertaining to the head of household and other relatives living in the same household by defining them as the target case of analysis; the first linear file was created based off of data that included the elderly person, the household, and on the head of household. The second linear file was created based off of the data collected about ever married children, siblings, and parents of the householder. The two linear files were then merged to include household data, head of household data, and if appropriate, extended family member data. It is through this sampling process that every elderly Chinese and Japanese was sampled for analyses, despite sex and marital status.

After the sampling process was complete, Kamo and Zhou differentiated elderly people’s living arrangements into seven classifications, which included extended family arrangements: non-householder, householder/spouse, with siblings/parents; and non-extended family arrangements: in nuclear family, living alone, in nursing home, in group quarters. The main geographic focus in this specific study was Hawaii and California, but there was a third category labeled as “elsewhere in the U.S.” A table is included below to show the breakdown of the categories and the results (Kamo and Zhou, pg. 551).
Measurement is very important when considering research methodology, so it’s essential that I include how Kamo and Zhou classified some of their measurements. They measured ‘Acculturation’ by foreign birth (1 = yes, 0 = no), Non-English usage (1 = yes, 0 = no), length of stay since immigration, and immigration. The original response categories were documented in five year or ten year intervals, so the category before 1950 is given a value of 40; the average is utilized for calculating the length of stay. The mean value for each length of stay among immigrants in each group is provided, and since the foreign birth is included in the calculation to partial out any effect of immigration status itself, regression estimates for the length of stay variable apply only to immigrants. Economic feasibility variables contain labor market status, income, and physical disability. If an elderly person was still in the workforce they would answer 1 for yes or 0 for no; income is based off of annual individual income; and physical disability was measured by the number of three kinds of disabilities applied to the elderly (0-3 would be applied based on if one was limited in work, prevented from working, and prevented from using public transportation). Lastly, demographic variables were included such as age, marital status,
and ethnicity. Age is measured by the self-reported years of age, marital status is measured based on if an elder is presently married (1 = yes, 0 = no), and ethnicity is measured by a dummy variable. A dummy variable is simply a numerical variable used in regression analysis to characterize subgroups of the sample in one's study. In this case, ethnicity was measured based on whether an elderly person lives in a country where more than 1% of their co-ethnic group lives. One very important step in Kamo and Zhou's research is the controlling for two variables regarding state of residence. They noted that it was imperative to differentiate those Chinese and Japanese that lived in Hawaii and those that stayed in California, as they have their own unique assimilation history. The Chinese and Japanese in California tend to be more "recent immigrants and urban", as stated by Kamo and Zhou. In turn, they created two dummy variables controlling for living in those states which are, as mentioned previously: living in Hawaii and living in California, and living elsewhere in the United States. The latter is treated as the reference category.

Without hesitation, one can see how research methodology has its own language. It's also easy to see how time-consuming doing such research on elderly Chinese immigrants can be. Having to control for multiple variables, creating several types of measurement tools, and using very precise and meticulous sampling methods can be challenging. The research done by Kamo and Zhou was even done using secondary data analysis, which eliminated the time of collecting the data, but even so, is still quite tedious. However, consider had they done primary data collection, which would have required more time, more money, and probably more research staff. The disadvantage of secondary data analysis is that the data may not answer the specific questions that the researcher has posed. Though Kamo and Zhou were only seeking to understand the living arrangements of Chinese and Japanese living in the United States, it
doesn't explain exactly why they chose the living arrangements that they did, at least not from
the perspective of a Chinese or Japanese individual; that type of study would have been
qualitative in nature but very interesting nonetheless. Referring back to the comparative analysis
table, however, it says that Chinese language was not used and nor was dialect in this particular
study, but there were no interviews being done that required interpretation or translation of any
kind, therefore it makes sense why it was not included.

Based on the research done by Kamo and Zhou, we do understand that filial
responsibility is especially important to Chinese immigrants and it is essential for the adult
children to take responsibility of their parents as they age. Elderly Chinese immigrants are much
more likely than non-Hispanic whites to reside in extended family households, specifically those
of their married children. Kamo and Zhou asserted that though Chinese immigrants and their
offspring's may be adapting to the mainstream culture of having a nuclear family and self-
support, many are still holding on to their traditional values of having an extended family and
kinship support (1994). In fact, elderly Chinese women who were unmarried were less likely to
be in nursing homes than their Japanese and non-Hispanic white counterparts. Unmarried,
elderly Chinese would be more likely to stay in their married child’s home than in a nursing
home or an unmarried child’s home. In a case where an unmarried, elderly Chinese did not stay
with their children, they may live in what is called a “rooming house”, which is explained as
“collective arrangements of ten or more elderly persons or as temporary housing, such as inner-
city hotels”. This concept was interesting, especially as Kamo and Zhou went on to describe how
rooming houses may function as an alternative to nursing homes for the unmarried elderly. With
the moral obligation for adult children to take care of their aging parents, there is no wonder why
there is little information on elderly Chinese immigrants and their residential settings. However,
for those who are staying in group homes or in nursing homes, more data should be collected in
order to assess these individuals in terms of health status and disparities.

I found the journal article by Kamo and Zhou to be very well done, as they assisted in extending the literature on immigrant culture and living arrangements. They discussed literary findings done on the subject prior to their research in terms of both their outstanding qualities as well as their limitations. The latter is very important in the field of research because if a researcher fails to look at other studies to see what could or could not be controlled or where confounding variables may have existed, there will be no actual progress in that topic or field of study. They recognized the limitations of prior research that used the same data and took it a step further to learn more, especially in areas that may have been overlooked. Kamo and Zhou also understood that this is secondary data collection and in order for them to receive more of the results that they expected there would need to be primary data collection.

Mui (1999)

There was a study done by Mui (1999) that assessed the files of 147 Chinese elderly immigrants by living arrangement and the function that stress and managing stress played in explaining depressive symptoms. When referring back to the table, one see's that the study is qualitative; the researchers used primary data collection and interviewed individuals in order to obtain their information. Descriptive statistics was used to analyze the material in this study. The location is unknown but Mui did state that it was in a U.S. metropolitan area. Also, the Chinese language was used in the interview process but the dialect was not specified.

The participants in the study were community-dwelling elderly Chinese immigrants who were approached and questioned by the author at congregate meal sites and senior centers in a northeast metropolitan area from December 1994 to December 1995. A Chinese version of the
Short Portable Mental Status Questionnaire was done to screen for psychiatric or memory problems, as those who did have these issues could not participate. Most of the participants in the study could not read or write in any language so the respondents were given the questionnaire through face-to-face interviews. All of the data was collected by the author who is a native speaker of Chinese. The questionnaire acquired information on social support systems, self-rated health status, stressful life events, depression, and socio-demographics; these also are the independent variables.

In order to measure depression in this study, Mui (1999) used the Geriatric Depression Scale 15-item Short Form, which also happens to be the dependent variable. The Geriatric Depression Scale is very widely used and acclaimed for measuring depression in older adults. The independent variables were measured as follows. “Social support was defined by five areas: size of social network, help provided by family members, satisfaction with the quality of family help, existence of a close friend, and contact with friends” (Mui, 1999). Elder participants rated their alleged health on a four point scale ranging from “excellent” to “poor”. Stressful life events were measured with “yes” or “no” answers to the following question: “in the past 3 years, did you experience the following events” and those life events were: children moved out, serious illness or injury of family member, family discord, unemployment, and financial difficulty. Socio-demographic variables (age, sex, marital status, income, language spoken, education, length of stay in the U.S., and living arrangements) were measured as well to determine contextual features of the sample. Regression analysis was used to assess the factors associated with depression in elderly Chinese immigrants.

Mui (1999) discovered that almost 33% of the elderly Chinese immigrants that stayed alone were 80 years and older and more than 50% was widowed. Almost 68% of the participants
Those Chinese immigrants that were living alone reported that they received drastically less assistance with activities of daily living and almost half of them were unpleased with the assistance they received from their family members. These findings were interesting to me because if they aren’t receiving the assistance that they more than likely need and they aren’t pleased with the assistance they accept from their family, then it’s possible that residential settings would be a better choice. I question elderly Chinese immigrants’ quality of life when
they aren't receiving optimum care by professionals but I also understand filial piety plays a huge role in their decision-making process. The mental status of elderly Chinese immigrants living alone was far worse than that of participants who lived with someone. Those living alone reported higher percentage in terms of life satisfaction in eight items which were: life is empty; often get bored; fear bad things; often get restless; worry about future; problem with memory; upset over little things; and feel like crying.

The study done by Mui (1999) did have a few limitations to take note of. The size of the sample was quite small so the results in this study probably would have been different had it been a larger sample. Mui questioned the reliability and validity of the social support measurements in respect of elderly populations. The self-rated measures could have been biased because of "the cultural norm of moderation in expressing feelings and emotions among Chinese" (Mui, 1999). This particular study would more than likely have generalizability to those older Chinese immigrants who live in the community and who are not mentally impaired.

Huang et al. (2003)

In 2003 there was a study done in a New York City municipal Nursing Home that aimed to examine the socio-demographic characteristics and health status of older Chinese newly admitted to a nursing home (Huang et al., 2003). This particular study was also quantitative, collected secondary data, and analyzed data using correlational/regression analysis. What is different about this study compared to the one done by Kamo and Zhou, however, is the fact that the data actually comes from a nursing home in New York, so it's a little more central to what I was looking for in my research.

As mentioned, Huang and his colleagues utilized secondary analysis using the electronically stored MDS Plus of residents admitted to an unnamed nursing home in New York.
City from November 1992 to May 1997. The MDS was created by the Centers for Medicare and Medicaid Services as an assessment tool of residents in a nursing facility. The MDS plus is more detailed than its predecessor, as it has 350 additional items that cover 16 areas of assessment including categories such as mood and behavior, cognitive patterns, psychosocial well-being, physical functioning, disease diagnoses, and medication use. The measurements in this study are: socio-demographic characteristics, health status, and morbidity. The socio-demographic characteristics comprised of age, sex, marital status, living arrangement, source of payment, responsibility in decision-making, and advance directive status. Health status had four different aspects which included: cognitive performance, physical functioning, mood behavior and patterns, and psychosocial well-being. Cognitive performance was evaluated using the MDS cognitive performance score and through that residents were classified into seven cognitive performance levels. Physical functioning was assessed using the Version III Resource Utilization Group, activity of daily living index which is generated from four ADL variables in the MDS. The scores ranged from 4 (completely independent) to 18 (total dependent). The final measurement, morbidity, was evaluated by using the prevalence of frequent diagnoses/conditions and use of medication. The term, “frequent” was defined as “when a diagnosis/condition was present in at least 15% of the residents in any racial/ethnic groups”. The morbidity measurement also included the number of medications used and if the resident was taking psychotropic medications for issues like depression or anxiety.

The study done by Huang and his colleagues (2003) used descriptive statistics and regression analysis. The descriptive statistics were used to convey a synopsis of socio-demographic status, health status, and morbidity. To test for equal means of continuous variables one-way analysis was used and a chi-square test was used for equal proportions for nominal
variables among the racial/ethnic groups. To control for Type I error across the paired comparisons between Chinese and each of the other groups, the Bonferroni approach was used. For clarity, a Type I error takes place when a false hypothesis is accepted and the Bonferroni approach is used when there are multiple independent or dependent statistical tests being performed concurrently, which require that the alpha level be lowered to avoid masses of spurious positives (http://mathworld.wolfram.com/). Logistic regression analysis was used to analyze the racial/ethnic differences to control for potential confounding factors and SPSS software was used for the statistics.

The results of the study were actually very helpful in understanding elderly Chinese immigrants and their living arrangements. Huang his colleagues (2003) stated that the average older Chinese immigrant was “a first-generation immigrant, admitted from an acute hospital, spoke primarily Cantonese or Mandarin Chinese, lived with his family, depended on a family member for decision-making, used Medicaid, and had no advance directives”. Even more appalling was the fact that almost 75% had cognitive impairments which were clearly underdiagnosed in the admission records. Most of the residents had 6.2 frequent diagnosis/treatments and almost half took five or more medications a day; one-tenth utilized psychotic drugs. Huang et al. made a remark about the health status of this group saying that, “although most published surveys on older Chinese in the United States suggest that this is a super healthy group, this study is a reminder that even the robust eventually become frail, develop dementia and other chronic diseases, and require long-term care.” Based on this study, dementia is claimed to be underdiagnosed upon admission and may actually be the reason why older Chinese are admitted into a nursing home in the first place; recall that this group is much more likely to stay with their kin due to filial obligations of the children.
The researchers made it clear early on how there was a disparity in obtaining data on this group by asserting that "older Asians are reported to have higher rates of educational status and income...however, older Chinese who lived in inner cities and spoke predominately Chinese were more likely to be underrepresented in these surveys" (Huang et al. 2003). This statement alone gives us an indication to why the study was done in the first place: community based studies done in the past failed to collect data on elderly Chinese immigrants in inner cities and there was a clear discrepancy. One important concept in research is to understand the limitations that may occur in your study. The older Asians who have better income and higher education are not representative of the elderly Chinese immigrants who are low income and poorly educated in inner cities. One common misunderstanding that occurs when research is reported is that people tend to make the findings universal, but the Asian population is very diverse; what may apply to one group may not necessarily be the case for the other. In this particular study, the elderly Chinese immigrants were interviewed by Chinese-speaking staff for the MDS, however there was difficulty in controlling for cultural perception and language barriers and how it could have affected the MDS recording (Huang et al., 2003). Though this study sought to investigate the discrepancy in elderly Chinese health status in nursing homes, one cannot assume that the study is generalizable to other Chinese populations in nursing homes in the United States.

Aroian, Wu, and Tran (2005)

Though we understand at this point that elderly Chinese immigrants are not as likely to reside in nursing homes, independent living and assisted living homes, there still needs to be more information on why this group does not utilize health care and social services more often. Aroian, Wu, and Tran (2005) did a study observing the reasons behind why Chinese immigrants abstain from using services despite their high need. The underutilization of service use among Chinese immigrants is very important because it is easy to assume that those who do not use
health care services as often are more likely to have poorer health outcomes. Even further, it would be interesting to know if those Chinese immigrants who resided in their homes instead of skilled nursing facilities had far better health conditions or far worse; the quality of care that adult children provide may not be the same quality as what can be provided in a skilled nursing setting. Ma (1999) discovered that Chinese adults in Houston over the age 25 did not use health services, even those that were traditional ethnic services (e.g. acupuncture) due to the following: “communication barriers, preference for self-care and peer advice, lack of health care insurance, not understanding insurance coverage, distrust of Western medicine, transportation difficulties, and barriers specific to managed care”. The reasons provided for the lack of health care service utilization given by Ma, however, may have been different if the study were done on strictly those 65 and older. For instance, Aroian et al. (2005) remarked that Chinese immigrant elders are eligible for Medicare and therefore would be more likely to have health insurance and to receive services outside of managed care than those that are younger.

Referring back to the table, the study done by Aroian, Wu, and Tran (2005) is qualitative; it also utilized primary data collection, was analyzed using both descriptive statistics and content analysis, and was done in a Boston Chinatown. The location of the study also notes that it was “personal”, which means that it was done outside of any type of residential setting. The study did require that the Chinese language be interpreted and translated and the types of dialect were also referenced. This study was set-up slightly different than the previous studies just because it is qualitative and it actually requires contact with elderly Chinese immigrants.

In the study done by Aroian, Wu, and Tran (2005) they conducted interviews with 27 Chinese immigrant elders, 11 adult care-giving children, and 12 health and social service providers. The adult children and elders were not related to one another and the providers were
not paired to respondents. The elderly Chinese immigrants were recruited via two social service agencies that target Chinese elders in the Boston area, including one agency in Boston's Chinatown and one agency in a neighboring suburb. The researchers kept in mind that recruiting elders from the social service agencies would possibly attract elders that were more likely to actually use the services, so they pursued other participants through network sampling. They did have criteria for participation for elders which included being from China or Taiwan, living in community dwellings in the Greater Boston area, and not being cognitively impaired. There were also criteria for inclusion in the elder and adult children groups, which included being age 60 or older or caring for a local, community-dwelling parent who was age 60 or older, even if the child was not living with the parent. Those who participated in the study tended to be elders who immigrated to the United States as older adults and more than half of them were from Taiwan. Most of the elderly participants also received government assistance due to having lower income, and therefore utilized programs such as Medicaid and/or housing subsidies. The social service providers that participated in the study involved four physicians, three social workers, two case managers, one Chinese acupuncturist, one clinical psychologist, and one executive director of a Chinese home care agency. Almost three-fourths of the providers were Chinese immigrants and more than half of them had Chinese immigrants as clients or patients.

Once the informed consent process was complete, semi-structured, open-ended interviews were done either on an individual level or in a focus-group. Open-ended questions were asked concerning the kinds of health problems prevalent in Chinese elders in order to prompt discussion. There were a total of 15 individual interviews done and there was one focus group with 12 partakers. The data collected from 11 adult children were done through individual interviews and the interviews with the 12 providers were done within a focus group. The focus
groups were specifically designed to collect general perceptions and differences among elderly Chinese immigrant health and social service use; the individual interviews were there as an addition to the group data. The data was collected in Chinese, besides the information that was obtained from the providers. The interviews were also done in Chinese and were interpreted by one of three research assistants who were bilingual in Cantonese, Mandarin, or Taiwanese dialects; they were paired with study participants corresponding to the dialect. The interviews were voice recorded and those that were done in English were transliterated verbatim. Those interviews conducted in Chinese were translated orally onto another set of voice recordings, and the translated English versions were transcribed. This process is very important because if not done correctly, essential material can be lost. The translations were done as exact as possible and explanations were given for idioms, metaphors, phrases, and medical terms that were not readily interpretable in English. The translations were not officially back-translated but were examined for accuracy by interviewers by comparing the original Chinese audio recordings against the English transcriptions.

In order to summarize the demographic data, descriptive statistics was used. Qualitative content analysis of the interview transcripts were done in order to assess the coding data. The researchers worked tediously with codes, beginning with generating the codes to topical areas or broad categories extracted from the interview questions. Following that, more detailed descriptive sub-codes were designated to data grouped under those broad categories. The next level of coding required that those same data be assigned sub-codes for items such as cost or language. In the final stage of analysis, the sub-codes were compared with the behavioral model for fit, according to how the sub-codes fit Andersen’s conceptual categories.
The study done by Aroian, Wu, and Tran (2005) had some very interesting findings. They found that Chinese elders based whether or not they used Western or traditional medicine on the nature of their health problem. Elderly Chinese immigrants also did not seek formal mental health services in spite of their issues with depression, social isolation, and conflict with their adult children due to their dependence on them. The social services they do seek may include elder housing, adult day care, and transportation to take the pressure off of their adult children, which thus gives them an ease of mind. On the contrary, amenities such as home-maker services, home health aids, and nursing homes were infrequently used as social services. This lack of social service utilization stems from their cultural values of providing self-care and the reliance of their family members. Speaking from my own experience as a Certified Nurse Aide, I recall having an elderly Chinese immigrant resident who suffered from dementia, but who still wanted to do most health care services for himself. Often times this resident would refuse medication saying that it was unnatural, despite his high blood pressure and various other chronic diseases. A comment made by one of the elderly Chinese in the Aroian, Wu, and Tran (2005) study said, “most of us will do self-treatment and not bother the family”, which is basically the concept that my former resident had with myself, other coworkers, and family members; they do not want to be seen as a bother.

Another fundamental concept brought up in the Aroian, Wu, and Tran (2005) study was that there were three notable service delivery problems which involved language, cost, and transportation. Chinese immigrants are less likely to utilize Western health care services when there is a language barrier and a lack of understanding, which could easily lead to reasons for trust and fear of the Western health care system. The fact that Chinese-speaking health care professionals and interpreters are not always readily available deters this group from seeking
basic services. It's also important to understand that there are several different Chinese dialects and those spoken by an elder and a health care professional may be different; most services are provided in Cantonese and that creates a limitation to those who speak other dialects. Cost only seemed to be problematic for elderly Chinese who sought traditional services which are not covered by health insurance; however for those who did have health insurance and could readily use Western medicine, they still were not more compelled to utilize it. In terms of transportation, there is difficulty in understanding how public transportation works for those who speak and read limited English so there is a fear that they may get lost. Despite the fact that services such as Medicaid provides rides to appointments, elders were not pressed in having drivers who do not speak their language. Family members are the main sources of transportation but this is of an inconvenience to them because most of them have jobs and therefore have difficulty in working around their work schedules; situations such as this are why elderly Chinese immigrants result to self-care.

There were some limitations to the study done by Aroian, Wu, and Tran (2005). As mentioned previously, their sampling strategy of originally recruiting participants from social service agencies may have brought in people who were most likely to use health and social services in the first place; that information would not be generalizable to those who do not use health and social services. The participants were also asked to give their thoughts of Chinese elders as a group which could easily result in generalizations and stereotypes; evaluating individual variation was beyond their scope of study, however. One very important aspect of this study is the fact that it is a replication of a study conducted with elders from the former Soviet Union, which means that this study could very well be replicated for other immigrant groups in the future.
A study done by Brugge, Kole, Lu, and Must (2005) hypothesized that elderly Asian immigrants in a Boston Chinatown would be more likely to imply that they could be persuaded to join a research study. Referring back to the information in the table, this study would be considered qualitative and the data was collected by the researcher. The material was analyzed using both descriptive statistics and correlational/regression analysis and it was also done in a Boston Chinatown like some study. The Chinese language was used when conducting the interviews and they did mention the type of dialect. For clarification, this study was not specifically about elderly Chinese immigrants in residential settings, but I found it to be important to include because it gives a better indication of what would encourage Asian immigrants to partake in research studies in general. Research cannot be done if people aren’t willing to participate in the study so it’s essential to know why they wouldn’t and what would help in convincing them that research on their group is very important.

In the recruiting process, Brugge et. al. (2005) sought to retain two different populations, one immigrant Chinese and one non-immigrant Chinese. In the Chinese group there were a few individuals who were not from China or Hong Kong but were still included, so during the process of recruiting they changed the group names to “Asian” and “non-Asian” groups. There was a health fair that aimed to recruit the elderly Chinese population of Chinatown. The fair was comprised of several health stations which offered educational materials or services such as blood pressure readings. The health fair was put into action by the Community Advisory Board of the Human Nutrition Research Center and The Greater Boston Chinese Golden Ages Center, which is a community based service agency (GBCGAC). Since most of the Chinese participants did not usually write or read in English, the written materials were translated into Cantonese and then back to English; oral translation was also provided as well. The data collection consisted of
a total of six questions asked pertaining to research participation from 79 participants. The data collected was done through both self-administered and interview administered surveys, in a written format. There was a problem with the translation process because one of the questions used a letter in the Chinese language that was similar to another letter with a different meaning. The question was omitted from the survey even though they caught the mistake early-on in the process. On the other-hand, the non-Asian surveys were made up of the same questions but the participants were required to understand written English so that they could effectively fill out the survey. The Non-Asian surveys were conducted at different sites including a Foster Grandparent Meeting and at a Senior Center, a total of 58 surveys were obtained. For this particular study, the informed consent process for both surveys was deemed exempt.

Descriptive statistics was used in the study done by Brugge and his colleagues (2005) in order to differentiate the two groups. Group assessments were made using the chi-squared test, Fischer's Exact test, and 2-sample $t$ tests. Logistic regression analysis and multivariate analysis were used to contrast the two groups after adjustments for demographic characteristics were done. All the analysis was conducted using SPSS software.

The results of the study done by Brugge et al. (2005) found that factors such as familism, reverence for authority, and a sense of shame/pride may motivate Asian Americans to participate in research studies. Familism is very important to Asian culture, as the decision-making process is family centered. One does not want to bring shame or embarrassment to their family so it is best to always consult with one's family members about participating in research, as opposed to making an individual decision. Reverence for authority implies that those who are in positions of power are to always be respected because they are considered educated. This presents difficulty in Asian culture because they believe that questioning someone who holds a position of
authority, especially an elder, is insulting and can result in shame to the family. Familism and reverence for authority are especially difficult for those in Western cultures to understand because individualism and independence is practiced more often. This creates problems when conducting research because though researchers attempt to understand the concepts of familism and reverence for authority in order to gain Asian participation in research studies, research ethics guidelines are based on individualistic concepts.

The purpose of the study done by Brugge and his colleagues was “to compare the susceptibility of Asian and non-Asian populations to influence from their children, landlords, physicians, a newspaper ad, and an offer of money in regard to participation in the research study”. The results of the study indicated that the Asian group was more susceptible to change their mind about participating in a research study if family or those in positions of authority told them not to do so. Asian participants were even less influenced to respond to a newspaper ad or to the offer of $50 for participating in a survey; these offers were not persuasive to the non-Asian groups at all. The risk of coercion, or forcing an individual to take part in an act involuntarily, is greater in elderly Asians, especially those that are Chinese immigrants, due to the extra precaution that goes into the informed consent process with elderly Chinese immigrant populations. Brugge and his colleagues (2005) suggested that it may be appropriate to “[find] ways to convey informed consent that takes into consideration differences in culture, class, and other factors”. Though incorporating the Chinese views of familism, respect for authority, and shame/pride into the Western view of individualism and autonomy may be difficult for those who conduct research, it may be helpful in leading research projects with this group in the future.
Yeung et al. (2009)

There was a pilot study done by Yeung et al. that sought to investigate the feasibility and effectiveness of providing telepsychiatry services to Chinese immigrants in a nursing home (2009). Referring back to the table we know that this study is qualitative but it is also a pilot study. A pilot study is typically a smaller experiment or observation that is done before a large project in hopes of correcting any inadequacies. This study was done in a nursing home and the data was collected through follow-up interviews. They analyzed the data using descriptive and interpretative methods, which is basically deciphering what the results were and finding any underlying meanings. The Chinese language was used in this study, however the dialect was not mentioned.

The study was done at South Cove Manor in Massachusetts which has a bilingual staff provided for its nursing home population of elderly, Chinese speaking immigrants. The participants of the study were residents of the nursing home who had been referred by the staff for psychiatric consultation. The principal investigator is a bicultural and bilingual Chinese American, board certified psychiatrist and had initially interviewed the patients in-person at the nursing home. After the principal investigator assessed them he told them about the prospect of participating in this study and receiving video-conference based follow-up visits. The ability of the participants to describe what the study was about confirmed their competency to partake in the study. Those individuals who were not considered competent had to receive permission from their guardian or next of kin to seek their consensus to enroll those patients in the study. This study was approved by the MGH Institutional Review Board. (Yeung et al., 2009)

The principal investigator conducted the follow-up interviews with the patients by video-conference. The nursing home staff was sometimes asked to join the participants in the room
during video-conferences for issues such as hearing impairments or if there was difficulty understanding. Depending on the clinical condition, there was a range of two to five visits and the visits were prolonged until the need for the visits was effectively addressed. The subjects were given compensation for participating in the study.

Feasibility was said to be established if the subject showed up and participated in the video conferences for follow-up after the initial first visit. Using the Clinical Global Impressions-Improvement Scale, the principal investigator rated each patient's clinical improvements at the conclusion of the follow-up visits. The tele-psychiatry services were surveyed using a satisfaction questionnaire given to the patient and the charge nurse.

Based on the findings, mental health disorders are found to be undertreated due to regulations and policies that affect the providing of mental health services in nursing homes, and the issue is even greater for immigrant nursing home residents (Yeung et al., 2009). There is a shortage of mental health professionals who can provide psychiatric counseling that is both linguistically and culturally appropriate for ethnic immigrant populations (Yeung et al., 2009). The disparities that led to the reasoning's behind this study are why research is so important, especially concerning elderly, Chinese immigrants in residential settings. The literature is so few where the need is so great; appropriate research methods should be in demand for a group that is growing so fast. This particular study only assessed nine residents in a nursing home in Massachusetts due to the small number of Chinese immigrants that resided there. Most nursing homes provide services for those in the majority, which makes it difficult for ethnic groups because of language difficulties and cultural incompetence (Yeung et al., 2009).
The limitations found in this study were the small and diverse sample, as well as the fact that some of the subjects had dementia and psychotic symptoms that could have affected their responses (Yeung et al., 2009). Also, the assessments were based on subjective ratings from nursing home staff where bias could have been posed. The pilot study cannot be considered generalizable to all nursing homes with elderly Chinese immigrants because this particular nursing home was tailored for ethnic immigrants, which most nursing homes are not.

Overview of Studies
After reviewing all of the studies I observed that there were more qualitative studies done than quantitative. I also observed how only two studies were actually specific to residential settings and the rest were just assessing living arrangements or health services. Nonetheless, I found those that were not exactly pertinent to elderly Chinese immigrants in residential settings useful because they offered perspective. The studies gave insight to why Chinese elders may not participate in a study or why they may avoid Western health care services all together. I noticed how only nursing homes were assessed in the research I found, but there was nothing about assisted living centers, independent living communities, or group homes included. In addition, I noticed how most of the participants in the study, if not done in a nursing home, were located in a Chinatown on the east coast. Considering the fact that California has a large Chinese immigrant population, I was surprised not to find much information that addressed some type of issue concerning residential settings in that state.

A reoccurring issue that I observed from these studies is an under diagnosis of mental health problems in both elderly Chinese immigrants in residential settings and those that live at home or with children. The fact that mental health is of concern causes for apprehension about caregivers stress in handling these situations that go undiagnosed. I can only imagine that it
would be extremely difficult for a family member to take on the responsibility of caring for a parent who has dementia-like symptoms – that will go undiagnosed – and having to constantly monitor them, but believing that it is just a normal part of aging. There is a problem if even in the nursing homes, where there are professionals who are supposed to be able to identify mental health challenges, can’t evaluate them because of linguistic and cultural barriers. The research methods must be improved to find these areas of concern and to act on them, which is the only way there will be improvement.

Looking back, I realized that there are only a few results when keying in a search to find information on elderly Chinese immigrants. For example, if I type in the PubMed database, “elder” and “Chinese immigrant” and “nursing home”, the only result that will appear is an article about Filipinas as residential long-term care providers, which were not exactly the result(s) I was looking for. However, if you type in “elderly”, as well as “Chinese immigrant” and “nursing home”, nine results will be presented. Journal articles covering sub-acute care interventions, ethnic differences in in-hospital place of death among older adults in California, cultural predictors of caregiving burden on Chinese-Canadian family caregivers, and a number of other articles that are not exactly relevant to what I am looking for. If I key in another search consisting with the keywords, “elderly” and “Chinese immigrant” and “residential setting” there are no results on PubMed. It’s interesting that this thesis looked to assess the quantity and quality of research on Chinese immigrants in a residential setting but when it came down to using the keywords to find information, there were little to no results, therefore further expressing the lack of material on this group. Though language barriers may be an issue, as well as filial piety, cultural differences, and cultural competence – there should still be more information on the
topic at hand. A barrier was presented early-on when attempting to gain more material on the topic, as it began when doing a simple search.

Mellor (2009) stated that, “there is plenty of literature on immigrants and immigrant experience in the United States, but very little speaks to the older immigrant, both those who immigrate when older and those who immigrated at a younger age and are now elderly”, as it pertains to Asian immigrants. The fact that there is little information all together on Asian immigrants presents an obvious issue because there are several groups that identify as Asian including, but not limited to the following: Chinese, Filipino, Indian, Japanese, Korean, and Vietnamese. For the Asian population to be as large as it is, it is amazing that research is not done on this population as often.

Based on the information that I found while doing my research, I noticed that Chinese American immigrants are perceived as the “ideal” minority with no health problems, but this is far from true. As we’ve learned from the literature, many of their health issues go undiagnosed and untreated because of their limitations in accessing health care, especially considering the language barrier and potential transportation issues. Those in nursing homes are under diagnosed in both their mental and physical health because of the lack of specialized care directed towards those with ethnic backgrounds. Ren and Chang (1998) stated in their article, “this general perception of Chinese having good health has masked the serious health problems among the elderly Chinese Americans”.

Traditional Chinese culture has an impact on the health status of this population as elderly Chinese are more likely to perform self-care when they recognize that they are ill. Even more so, if they do seek services for health care they may utilize the ones provided in their city’s
Chinatown, where they will feel more at ease and less withdrawn. The problem with this however, is that Chinatown is known for its over-congestion, poor sanitation, and housing that is not up to par with the local housing code. Ren and Chang (1998) expressed how elderly Chinese were subject to higher cases of liver and nasopharyngeal cancers, stomach and rectal cancers, heart disease, hypertension, mental illness, suicide deaths, and more likely to smoke compared to Caucasians. Though Chinatown is not considered a residential setting, it is a place where many Chinese immigrants reside and it is important in understanding their culture and health. It would be an interesting study to see how many of those elderly Chinese immigrants in Chinatown end up going to a nursing home, and if so, what is the status of their health conditions upon admittance. It would also be stimulating to know the total number of residential settings (i.e. nursing home, assisted living, and independent living) in various Chinatown’s in the United States and the quality of their facilities. Further research should be made on this subject later, but advice on how to conduct research with this group is essential to understand first.

The pilot study done by Yeung and his colleagues further illustrated how great of a disparity there is in our understanding of mental health in Chinese American immigrants, especially those in nursing homes. The lack of knowledge on the mental health problems among Chinese immigrants is actually devastating, especially considering that this group has a high prevalence of depression. Lin (1986) reported that social isolation, lowered social status, and grief act as a few of the factors that attribute to the high prevalence of depression among elderly Chinese immigrants. Lee (1996) went a step further and found that acculturation stress, financial problems, and other social stressors associated with immigration also played a part in the increased prevalence of depression in this group. Would it not be of importance to know the mental health status of Chinese immigrant residents in a nursing home, independent living, or
assisted living? It is absurd that we do not have more research on this subject. Casado and Leung (2002) state that there are several reasons for the neglect of psychological distress among elderly, Chinese immigrants including the “model minority myth”, insufficient data, and the underutilization of mental health services by Asian immigrants. There is especially difficulty in accessing health care data for elderly Chinese immigrants specifically because the U.S. Census categorizes Asians and Pacific Islanders as one group. Therefore, the quality and quantity of mental health research on elderly, Chinese immigrants in residential settings is poor; the closest study one may receive is a pilot study, such as that done by Yeung and his colleagues.

Nursing homes and other residential settings that provide assistance outside of the home are not ideal for elderly Chinese immigrants; they simply go against filial piety, as mentioned before. Adult children feel that they have an obligation to care for their parents as they age. One adult child in the study stated: “if people put their parents in a nursing home, this is Chinese behaving like Americans. They think taking care of elder’s is the government’s business.” However, elder housing (i.e. retirement communities) and adult day care did not have the same equal negative association as nursing homes. In the Aroian, Wu, and Tran (2005) study they found that secretly Chinese elders wanted to attend adult day care and reside in elder housing because they would be less socially isolated and they wouldn’t have to depend on their adult children as much. Nursing homes and other residential settings are often covered by Medicaid, and in Chinese culture using government subsidies is not seen as meeting personal or family obligations. If adult children are to place their parents into a nursing home they are likely to pay out-of-pocket because they feel obligated to do so; Chinese have a mentality where they do not want to bother the government but they also feel indebted to take care of their parents.
Taking Action: Helpful Research Methods and Strategies

With the majority of Chinese in America being foreign-born and the population of this group being so large it is amazing that there is few research studies on their views of nursing homes and other residential settings. Though there are several factors that result in this notion, especially the fact that few Chinese immigrants utilize nursing homes in the first place, it is amazing that they are neglected with it being such a large ethnic group in America. Chinese immigrants are more hesitate when taking part in research studies and researchers may stray from this group because of human subjects’ guidelines; not only that, but Chinese immigrants are more likely to consult with their family members before taking part in a study, they don’t want to participate in any activity that could cause shame, especially if the researcher and his colleagues seem untrustworthy. Therefore, this leads to the actions researchers could take to make conducting research on this group easier. For such a large ethnic population, there is no excuse for having very little literature, especially in terms of residential settings and the future. With the baby boom population growing older and the large number of individuals in this cohort, the needs of elderly Chinese immigrants will have to be addressed. Will nursing homes and other residential settings become more of an option for Chinese immigrants in the future with the elderly population growing older and requiring more needs? It will be interesting to see how culture and health needs play out in the years to come. Nevertheless, I believe that it would be appropriate to express what other researchers think about certain research methods and strategies as it pertains to studying immigrant populations.

An article written by Huer and Saenz (2003) aids as a guide for researchers who take interest in culturally sensitive research and it identifies many of the challenges and limitations that occur when working with diverse groups. I found this article to be very helpful, especially in understanding the research methods that are used for this type of research (research with
immigrants or diverse populations). The article offers how research can be done more adequately and gives various strategies for developing appropriate methods.

The beginning of the research process is one of the most important stages and it is also very informative. Huer and Saenz explains how “it is very important to include individuals from the community of interest during all stages of clinical research endeavor, including the initial planning, preparation, data collection, and analysis phases”. This statement addresses how crucial it is to have an authority figure from the community of interest when conducting research. Consider the elderly Chinese immigrants who are hesitant to utilize Westernized medical practices and who are more likely to respect individuals of authority or family as opposed to those who haven’t yet earned their trust. The community and researcher should have a type of liaison that makes the participants feel comfortable with their involvement in the research; otherwise there will be difficulty in retaining individuals. Not only this, but researchers become more sensitive to cultural issues and the validity of the research findings. If one is conducting research on elderly Chinese immigrants it would be appropriate to have someone from the same culture, otherwise it’s a possibility for bias in the findings, which results in discoveries that could be disparaging.

The next step of conducting research with a culturally diverse group is to become familiar with the culture, or in other words, gain a sense of cultural competency. This means that the researcher should understand their history, customs, and style of interaction but be wary of not generalizing their findings. As Huer and Saenz (2003) stated, “Individuals may vary by age, exposure to the larger culture, age of immigration, socioeconomic status, [and] number of years in the United States”. All of those factors have an influence on the acculturation process. For clarity, acculturation is a process of psychological and cultural change as one culture adopts and
combines the beliefs and values of another (i.e. Chinese immigrating to America and adopting Westernized customs). An article was written by Trinh and Ahmed (2009) on the acculturation process of Asian American elderly and they made this comment: “the younger generation will find themselves conflicted between their sense of duty to their extended family and the adoption of American values that focus on individuality and the nuclear family”. Though this applies to the younger generation as they age, I would not be surprised if elderly Chinese immigrants are going through this sense of conflict now. Even more so, consider the fact that some elderly Chinese immigrants may be answering questions based on a westernized way of thinking, even if they do not firmly follow that belief. Individuals answering questions in a way that they suspect the researcher may want them to answer rather than being honest happens often in research involving surveys.

Researchers should be aware of the acculturation model (Locke, 1998) and understand the different levels of acculturation which are bicultural, acculturated, traditional, and marginal. Knowing these different levels makes researchers more aware of the group they are working with and makes them more privy to the answers they may receive. Huer and Saenz (2003) explains the different levels: a person that is bicultural has effectively adjusted to the new culture but also remains tied to their culture of origin; those that are acculturated have adjusted to the new culture but have also lost traces of their culture of origin; an individual at the traditional level does not adjust to the new culture and carry’s on to follow the values of their culture of origin; and an individual at the marginal level may follow the customs and values of the country of origin and new culture but only minimally. This is important because an individual, depending on their level of acculturation, may answer the questions in a different way based on their experience. Having an understanding that groups that have not adapted to the mainstream culture compared
to those that have adjusted may comprehend less English or be less willing to participate in surveys due to uncertainty or apprehension. If a researcher can get on a level where they can have a conversation with members of the community informally then it will put both groups at ease and the results of the research study may be more valid. Furthermore, a researcher should do an in-depth literature review of the group at hand which does not just consist of published journals but also includes literature in newspapers and dissertations (Huer and Saenz, 2003). This method is especially useful in subjects where there is few peer reviewed sources, such as the topic of elderly Chinese immigrants in residential settings!

After a researcher has selected a leader of the community as a liaison and done their research on the group at hand, they should begin deciding on the type of research design they will adopt. Huer and Saenz make suggestions based on the research they have done in the past and it really gives one a sense of direction on what to do depending on what they are looking for. For instance, surveys and focus groups are aimed towards obtaining participants opinions rather than information that is factual. In survey research that is self-administered, a questionnaire is usually written that is structured with closed-ended questions. These questions are typically formulated in advanced and have a scale that measures the question based on the answer given by the participant. The surveys, interviews, and focus groups that have open-ended questions tend to allow for development of participant-initiated concerns. On the other hand, survey research that is not self-administered, like that done during an interview, may involve several questions directed towards one individual; the questions in this type of research may be prepared beforehand but can be diverged if more information is sought. Surveys are convenient in that they can be done over-the-phone, in person, or by mail so it causes for ease on the researcher and participants. The problem with those surveys that are done in-person or by mail is that the
participant may only return them if they feel confident or positive in their answers as to not be judged by the researcher. In terms of focus group research, the idea is to bring up topics to a group in hopes of stimulating discussion through open-ended questions. Self-administered surveys do not warrant much elasticity when it comes to allowing the researcher to adjust or revise the survey based on the concerns of the participant taking the survey; for more flexibility one should look into conducting interviews or configuring a focus group. A researcher who is conducting a self-administered survey should have a “strop grasp on literature and ask relevant questions in a culturally sensitive manner” (Peter, 2000). This particular type of research leads to quantitative analysis with preset assumptions that prompt the collection and analysis of the data. Focus group and survey data is convenient when doing culturally sensitive research but a research team should be aware that interpretations after analysis may be biased.

Huer and Saenz (2003) also discuss in their paper the essentials of organizing the clinical research instrument when working with diverse communities. They state a research team should understand the purpose of their research, the language at which the final instrument will be presented, and potential areas of error while doing research across cultures. If a research team understands these concepts they will comprehend that culturally sensitive groups may be hesitant to participate in fear of being judged or the feeling that they will appear unfavorable in the literature; they will also recognize that what works for one group may not apply to another. Consider all of the studies mentioned in this paper; they all had a central purpose, all of the qualitative studies made reference to the language and translation process, and they all stated the limitations that may be present in their study. Basically, a sense of direction makes it easier to explain to one’s audience and most importantly to the group one is asking to participate. An individual that participates in a study is rarely doing so if there is no benefit in it for them – they
are expecting that better resources will result from them providing information or they were influenced by the compensation or gifts of partaking in the research; the latter is sometimes the case. Although a study mentioned previously in this thesis stated that Asian groups would not be easily swayed by compensation to participate, I believe it all depends on the individual and their needs.

Huer and Saenz (2005) recommend that the data collection process be thoroughly planned out when working with culturally sensitive groups. An emphasis on training researchers, moderators, and community liaisons is suggested as to educate individuals on those “what if” scenarios when something goes wrong in the data collection. Consider the study done by Brugge et al., (2005), when one of the questions used a letter in the Chinese language that was similar to another letter with a different meaning. They had to decide whether to keep it on the survey and correct the question or if they should completely omit it, which they did the latter in hopes of ensuring less complications with measuring the question later. Scenarios like this will arise when leading research so having an idea in mind for the “what if” situations is not a bad idea.

Lastly the interpretation and analysis of the study should be done very carefully as to reflect the actual views of the participants. Huer and Saenz (2005) suggest a “check and balance” with liaisons and members of the community to make sure that what has been stated has been interpreted correctly. Avoiding the imposing of bias during this stage of research is important as well because assuming what one means defeats the purpose of doing the research all together. If research is supposed to be a means of communication it’s important that one communicates the right findings and results.
Conclusion

In assessing the quantity and quality of research methods on elderly Chinese immigrants I observed a few unlikely concerns. Firstly, I learned that there was not much information on this group at all as it pertains to them and residential settings. I became aware that most of the research has been done on the east coast, which is interesting because there is a large west coast population of elderly Chinese immigrants in California as well. Correspondingly, I learned that most of the research done used qualitative methods and was consistent with the Iluer and Saenz (2005) article on suggesting that this would be an appropriate method when conducting research on culturally sensitive groups. I believe that qualitative research is a good strategy for elderly Chinese immigrants as it gives us a perspective on what the needs of this groups really are. In the future more quantitative methods can be applied in the field depending on the nature of the problem. In addition, the research I did come across showed me that Asian sub-groups are assumed to have the same health care circumstances despite their unique differences. In all honesty, these groups may share several cultural ideologies but their reasons for coming to this country are very different, which could influence how they respond to researchers and the use of westernized medicine, especially as it concerns residential settings. Similarly, it’s hard to say what the quality of the research is because we simply don’t have much to compare it to because the lack of quantity. These are things that we will have to figure out as research methods and strategies advance for immigrant groups.

Research is vital to the health care system and it is a necessary means of communication. Understanding the elderly Chinese immigrant population in our country is important if we plan on addressing the needs of this group. The fact that we don’t truly know our immigrant population and their cultural beliefs hinders us from understanding how to approach them to learn more about them in the first place. Truth is, since we do not readily know their health care
needs it means that problems that could effortlessly be addressed continually progress until it’s either a chronic disease or a fatal issue.

We have to learn more about the elderly Chinese immigrants that reside here because they will be a large part of where our health care needs and services go in the future. Not only is learning more about the elderly Chinese immigrant population essential, but it helps in becoming competent about other immigrant populations as well! If research can be done on one immigrant group successfully then being able to replicate that method on another group would produce vast results; we will discover findings that we need to deal with the setbacks of the groups we don’t know much about. The expectations of our health care system have yet to be dealt with when it relates to immigrant groups and health care services. Having a perception of where our immigrant populations may reside in the future for long-term care needs is important because if we don’t know the demand, then the health care system will have difficulty in bringing forth the supply. The current expectations are therefore unclear and need to be sought as it relates to residential settings and other health care service issues alike.
Bibliography


