

Intergenerational Relations and Elder Care Preferences of Asian Indians in North Carolina

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Abstract:

The US older population is growing in ethnic diversity. Persistent ethnic disparities in service use among seniors are linked to structural barriers to access, and also to family processes such as cultural preferences and intergenerational relations. There is sparse information on the latter issue for immigrant ethnic minority seniors. Information on the Asian group (the fastest growing senior sub-population) is extremely scarce, due to this group's diversity in national, linguistic, and cultural origins. We conducted a qualitative study among community-dwelling Asian Indian families (including at least one member aged 60 years and older) in North Carolina to examine preferences of seniors and the midlife generation regarding elder care, and the role of intergenerational relations in desired care for elders, exploring the theoretical perspective of intergenerational relationship ambivalence. Our results suggest that cultural preferences, ambivalence in intergenerational relations, and regulations on health service eligibility among immigrant/transnational seniors and midlife adults influence preferences for elder care.

Keywords: Asian Indians | Intergenerational relations | Ambivalence | Elder immigrants | Transnational families | Family care | Coresidence

Article:

Introduction

The US senior population is increasing in size and ethnic diversity, due to lower birth rate of US born non-Hispanic Whites, the aging of immigrant populations, and the immigration of seniors to join their families. According to the U.S. Census Bureau, in 2009, about 11.7 % of the US population 65 years and older was foreign born. The older population in the US shows persistent ethnic disparities in health (Sudano and Baker 2006), partly due to the differential access to and use of appropriate services among minorities (Carillo et al. 2011). Differences in service use

stem from structural barriers to access, availability, and affordability, and also from diverse cultural preferences and attitudes (Hernandez and Newcomer 2007). Immigration, which increases ethnic diversity, raises the proportions of seniors who have different cultures and eligibility for programs, highlights social change, and is thus important to consider when providing appropriate and accessible services to diverse seniors (Bhattacharya and Shibusawa 2009).

There is less information on how intergenerational relations in the context of immigration shape preferences for elder care among ethnic minorities. Emerging research points out the importance of global connectedness, and dynamic transnational family networks among diverse immigrant groups and their senior members (Agarwal and Das Gupta 2013; Bhattacharya and Shibusawa 2009; Patel 2011; Victor et al. 2012), but studies on this topic are comparatively few. In the US, information on Asians (the fastest growing ethnic sub-population) is particularly scarce (Cho et al. 2004; Humes et al. 2011). The tremendous national, linguistic, and cultural intra-group variation within the Asian community, termed “diversity within diversity” (Mui and Kang 2006, p252), makes research challenging, and necessitates gathering information on specific subgroups to build up an overall picture (Mui and Shibusawa 2008). Prior large-scale national data collection efforts in the US have typically not included sufficient sample sizes to analyze Asian subgroups in detail (Islam et al. 2010). Therefore, smaller scale studies of specific subgroups contribute toward aggregate understanding, improved policy design, and ultimate reduction in ethnic disparities in health among seniors (Lee and Angel 2002).

In this study, we examine the desires and intentions for elder care among Asian Indian seniors and their families, exploring the role of changing intergenerational relations in the context of immigration. We focus on Asian Indians in North Carolina, one of the “new growth” states in the United States. These states, located mostly in the US South, Midwest, and Mountain/West regions, have attracted a very large number of immigrants in the last decade (Hero 2010, p 447; Hoeffel et al. 2012).

Background

Asian Indians in North Carolina

Though Asian Indians have been present in the United States in small numbers since the 19th century, their immigration increased after the Immigration and Naturalization Act (also known as the Hart-Cellar Act) of 1965, which emphasized skills-based immigration, lifted racial quotas, and permitted immigration from Asia and Latin America (among other regions). During the last two decades, Asian immigrant groups are among the fastest growing in the United States. Asian American immigration patterns are characterized by substantial elder immigration and family reunification streams (Voon et al. 2001). Asian Indians now form the second largest Asian subgroup with one of the fastest growth rates (Misra and Gupta 2004). Nationally, this group grew 106 % between 1990 and 2000 (US Census Bureau 2010).

North Carolina is a “new gateway” state for immigrants from many regions. The United States 2010 Census showed that the number of persons in North Carolina reporting Asian Indian ancestry was 63,852, out of a total state population of 9, 535,483 (about 0.67 %). This proportion would be higher if those from adjacent South Asian regions (e.g. Bangladesh, Pakistan, Nepal, Sri Lanka etc.), who share broad cultural similarities with Indians were also included. North Carolina is in the top three states for growth of the Asian population during 2000-2010, and the Asian Indian population is the largest Asian subgroup in North Carolina and 22 other states of the United States (Hoeffel et al. 2012).

The 2010 Census further showed that, in common with most recently immigrated populations, the Asian Indian subgroup in North Carolina was comparatively younger (median age 30.9 compared to the state median age of 37.4; about 5.3 % of Asian Indians are over age 65 compared to about 12.9 % statewide); was comparatively better educated (about 78 % of Asian Indians have a bachelor’s degree or more, compared to about 26.5 % of all NC residents); and had a higher per capita income (84,357 vs 44,958 for the state in 1999 dollars); than the overall population of the state.

Asians Seniors’ Use of Formal Health Services

In the US, minority seniors use formal services at a lower rate than their White counterparts, despite having worse health and poorer socioeconomic profiles. Asian groups use fewer services and participate the least in health services funded by the Older Americans Act of 1965 (Mui and Shibusawa 2008; Liu 2003; Pang et al. 2003). Different Asian subgroups perceive barriers to service use based on immigration status and duration, work history, living situations, language, and driving ability (Lee and Angel 2002). Anti-discrimination laws and higher public funding have increased nursing home use for African Americans, but nursing home use among Asians, Hispanics and Native Americans appears much lower than for Whites or Blacks (Pandya 2005). There is very limited information on the use of alternative models of residential care, such as continuing care facilities, board and care facilities, senior day cares, etc., among other minorities. For all minorities, structural barriers (e.g. availability, affordability and accessibility of services, lack of knowledge, lack of insurance or of eligibility etc.) are great, and cultural factors (e.g. language differences, cultural preferences etc.) also play a role. Immigration also alters family relationships to influence perception and use of care among Asian groups (Kuo and Torres-Gil 2001; Pang et al. 2003).

Importance of Family Caregiving: Do Asian Seniors Desire Family Care?

The role of family in care-giving among ethnic minority seniors is central (Pandya 2005). Studies suggest that Asian and Hispanic immigrant communities are more likely to form extended families, depending on assimilation and resource levels (Glick et al. 1997; Gurak and Kritz 2010). Information on how intergenerational relations influence perception of care alternatives is thus needed. Chinese American seniors no longer expect forms of support based

on classic filial piety as they adapt, and acknowledge their children's adaptation, to U.S. circumstances (Pang et al. 2003). The seniors' health-seeking behaviors reflect this change, though family members still play a major role in seeking formal care. Recent popular media reports (e.g. Patel 2007) suggest that among South Asian immigrant seniors, there is a near-taboo on discussing moving to a facility for care, but the reality of the increased need for non-familial care is evident. Though seniors expect family care, there is not enough discussion and communication on this topic across generations. Research is needed to clarify these issues.

Theoretical Approaches

Roles and Expectations

Research highlights the importance of Asian immigrant adaptation to the host culture and resulting changes in intergenerational relations, for seniors' expectations of family care and adult children's attitudes toward providing it. Many South Asian families appear to feel a role conflict while taking care of their elders, though stronger norms of filial piety lower the perceived care burden (Gupta and Pillai 2002). The expectations that South Asian daughters-in-law provide care to older parents-in-law, are particularly strong (Bhattacharya and Shibusawa 2009). Diwan et al. (2011) found changing patterns of filial obligation among South Asian immigrant families related to preference for elder care. While current elders mostly lived with their children, very few in the midlife generation wanted to move in with their children in the future, but preferred to move in near them, or to a retirement community geared to their culture and customs, or even move back to India. However, considering additional theoretical perspectives that address intergenerational relations will add evidence to the issues and further clarify the bases of roles and expectations.

Transnational Family Processes

Intergenerational relations are shaped by the processes of international migration and formation of transnational families. Transnational families are increasingly common as some family members migrate and leave others in the country of origin, but still continue to have ties with each other (Lunt 2009; Zechner 2008). The process of immigration is long drawn out, and different members of the same family often have different immigration statuses, which affects their eligibility for and use of services, which in turn shapes their intergenerational relationships, intimacy, and support exchanges (Lamb 2002; Lee and Angel 2002; Lunt 2009). Transnational family intimacy is facilitated by proximity rather than by money transfers. Migration is no longer a one-time event. For example, among middle class South Asian groups in Canada, United States, and the United Kingdom, seniors move back and forth as health and financial circumstances dictate, creating multiple worlds they must negotiate (Agarwal and Das Gupta 2013; Bhattacharya and Shibusawa 2009; Patel 2011; Victor et al. 2012). Most Indian seniors in Lamb's (2002) study were no longer confident of intergenerational ritual reciprocity, but still expected material and social reciprocity, with implications for care expectations, co

residence, and intergenerational exchange, even among families who received state support such as SSI (Supplemental Social Income, a program for low income seniors who do not qualify for Social Security retirement benefits), meals, or Medicare. On the other hand, elderly immigrants sometimes prefer not to live with families, or have mixed feelings about intergenerational coresidence, due to the gap between cultural expectations of residence and interaction with kin, and structural constraints on these interactions (Lunt 2009; Lamb 2002; Treas and Mazumdar 2002; Voon et al. 2001). The social structural and psychological reasons underlying these gaps in expectations are more explored by theoretical approaches evolving from intergenerational solidarity and ambivalence theories.

Intergenerational Relationship Solidarity

Historically, South Asian families lived in patrilocal, multi-generational households. Such arrangements are often unsettled by international migration and transnationalism where migrants cannot always determine for themselves who constitutes their family (Burholt 2004; Lunt 2009). Family reunification migration streams often include elderly members who relocate to be near their children. Migration, urbanization, extra-familial work participation etc. have been hypothesized to reduce intergenerational co-residence and support. However, research in Western societies shows that intergenerational solidarity is maintained under these forces (Silverstein and Bengtson 1997). Further, the notion of intergenerational solidarity has been critiqued as having a one-sided focus (only positive) on family relationships, and not acknowledging elements of dependency, mixed feelings, and conflict within families (Luescher and Pillemer 1998).

Intergenerational Relationship Ambivalence

These multifaceted aspects of family relationships are included in theoretical advances that examine “ambivalence” in intergenerational relations. Intergenerational relationships can be ambivalent on two dimensions: social structural, and psychological (Luescher and Pillemer 1998). In social structural terms, ambivalence occurs when members of a family occupy roles or positions that require contrary feelings or behaviors, e.g. when balancing a desire for autonomy with the need for interaction and help. In psychological terms, the gains as well as strains of close proximity reflect potentially conflicting emotions that arise in relationships (Guo et al. 2013). Ambivalence appears more evident in closer vs. more distal family relationships (e.g. parents and children vs. wider kin) (Fingerman et al. 2004). It is also structured by gender, and is specifically evident in the care-giving relationship (Willson et al. 2003). However, though ambivalence is a promising theoretical framework to understand intergenerational relationships it has been less examined among ethnic minority and immigrant communities in the United States, particularly in relation to immigration and resulting elder care needs and choices.

Theoretical Framework and Research Questions

The present study is framed in the theoretical approach of intergenerational relationship ambivalence. We explore the expressions of positive and negative intergenerational relationships among Asian Indian seniors and their adult children. We gather empirical evidence of views and expectations of elder care among Asian Indian seniors and their midlife children, highlighting the role of changing intergenerational relations in the context of immigration, focusing on changing views and care expectations across generations.

Research Questions

To address the theoretical and empirical issues identified above our research questions are: 1) what elder care arrangements are desired by Asian Indian seniors? 2) what are the desires and intentions of midlife family members regarding elder care for seniors? 3) what role do intergenerational relations in the context of immigration play in desired care for elders?

Data and Methods

Study Design and Participant Selection

In 2007, the author and a graduate student research assistant conducted a qualitative study among community-dwelling Asian Indian families in Wake, Orange, and Durham counties of NC, which have high concentrations of this ethnic group. We began with personal introductions, and then used snowball sampling methods to contact families with at least one member aged 60 or above who would be willing to participate in an interview. We were interested in this population of seniors regardless of where the senior was residing, i.e. in the US or elsewhere, with family or independently. Our interview participants included midlife adults (who had senior parents) and seniors (who had midlife adult children). We interviewed members of 18 households, both spouses where possible, to ascertain male and female perspectives within the family. Interviewees included five older adults (3 female and 2 male) and 19 midlife adults (9 female, 10 male).

Our sample size was predicated on the need to ensure similarities and variations in information from participants (Rubin and Rubin 2011), and on Bernard's (2012) assertions of adequacy in size to capture the range of information presented. Depending on the qualitative study designs and goals, 20 participants is an adequate sample size to generate rich data. Beyond 20 participants, hardly any new information comes up. Our study goals were to ascertain preferences on elder care, and patterns of intergenerational relationships, among Asian Indian immigrant elders and their adult children. After interviewing 24 participants we found that no new perspectives were offered and little variation was being generated during interview conversations, so we ceased data collection (Patton 2001).

Data Collection

Our in-depth interviews were guided by a schedule of questions that aimed to explore our research queries. The questions explored views about intergenerational co-residence from the perspectives of both generations and genders. We also solicited views on intergenerational relations and positive and negative aspects of co-residence. Our interview guides were designed using an iterative strategy where concepts that emerged in initial interviews were introduced as probes for subsequent conversations, to ensure we captured similarities and variations in perspectives throughout the process. We asked subsequent follow up and probe questions as needed (Rubin and Rubin 2011).

Examples of interview questions for midlife adults included: “Where are your parents living these days and with whom (i.e.: do they live with you or plan to live with you?)”. Follow up questions included for example: “What are the reasons for this choice” and “What do you or would you/your parents like or dislike about living together”. Probe question examples included: “What led to the decision for your parents to stay or not stay with you” and “How do the different family members get along?” We also asked midlife adults: “Do you foresee living with your children when you are old/retired?” For those above age 60, we asked similar questions customized for whether or not they lived with children: for e.g. “How long have you lived in the US”; “Are you living with your children?” or “Would you consider living with your children?” Follow up questions included: “What would be some positive or negative aspects of such living situations?” and “Would you consider residential care?” Probe questions included asking reasons for their choices, or requesting more detail.

The author and the research assistant both participated in conducting interviews. Throughout the process both the author and graduate student researcher were attentive to their role and influence as data collectors, instruments of analysis, and personal positioning as “insiders” and how this may shape the interpretation of findings and overall rigor of the study (Watt 2007). Both share professional interests in the social science fields of Gerontology, Family Studies, and Demography, and have personal interest and experience due to their parents aging, their experiences of immigration and transnational families. These interests and experiences sparked the interest of the author in exploring ambivalence in intergenerational relations.

Both researchers had familiarity with the culture of the participants. However, the author shares regional culture with most of the participants, being fluent in English, Tamil (a major South Indian language which most participants spoke), and Hindi (India’s national language, which many Indians speak). In contrast, the research assistant while sharing national background with the participants, is from a different region, and is fluent in English, Hindi, and two Northern Indian languages. The advantage of this arrangement was that subtle regional differences in meaning that may have been missed, or biases taken for granted, were noted (Patton 2001). All the interviews were conducted in English, as the participants were all multi lingual and sufficiently familiar with English to prefer conducting interview conversations in this language, though occasionally they would insert a word or phrase in another language into the conversation, which were translated by the author.

Data Analysis

The author and research assistant took turns transcribing taped interviews and generating field notes. This procedure allowed us to identify missed information and inconsistencies if any. Transcripts were reviewed after each interview, independently by both researchers, who then compared interpretations and discussed any differences until consensus was achieved (Barusch et al. 2011). This process facilitated engagement with each others' reactions, biases, and interpretations, which enhanced analytic depth (Patton 2001). Themes and variations were identified, emergent themes and subthemes noted, and followed up in subsequent interviews. For example, from the information gleaned through analysis of the initial interview transcripts, we were able to derive additional questions such as asking subsequent participants their knowledge concerning Advance Directives and end of life care issues, as well as solicit their recommendations on what programs could help other seniors like them. This process was followed until no new information or recurring topics were evident in subsequent interviews.

Results

Participant Characteristics

All of the families interviewed are from a professional/middle class stratum of society, engaged in occupations such as engineer, scientist, higher education, accountant/bookkeeper, management, or in the technology sector. All participants were foreign born, and most had Southern Indian cultural origins, from Tamil or Telugu ethnic groups. At the time of interviewing, most midlife adults and older adult participants had obtained US citizenship. However, many of the older generation (i.e. parents/in laws of the midlife adults) were waiting to transition to US citizenship, holding immigrant visas or green cards. While all midlife adults had substantial work histories in the US sufficient to qualify them for Medicare and Social Security, few of the older adults qualified for these benefits because of the time frame and circumstances of their immigration, e.g. immigration after 1996, when the PRWORA Act (also known as Welfare Reform) had been passed, restricting the eligibility of older immigrants for Medicaid. All participants in the midlife age group had at least one elderly parent or parent-in-law alive, and four of them had older parents who were in the process of immigration. All of the participants were members of 'transnational' families in that they had close family members in other countries (including the country of origin) and family members with diverse immigration statuses. Some participant characteristics are presented in Table 1.

Table 1. Participant characteristics

Household	Person	Sex	Age group	Household/residence	Occupation
1	1	F	Midlife	Wife, young children, elderly parents live in India, visit every year to maintain visa	Professional
1	2	M	Midlife	Husband of above. His parents are moving to the US to coreside.	Professional
2	1	M	Midlife	Husband, young children. Extended family, including one set of elderly parents, and all their married children and grandchildren live in the same neighborhood. The other set of elderly parents live in India, and visit.	Professional
2	2	F	Midlife	Wife of above	Professional
3	1	F	Elders	Wife. Parent of Household 2. Extended family lives in neighborhood and nearby towns.	Retired professional
3	2	M	Elders	Husband of above	Retired professional
4	1	F	Elders	Wife. younger generation is settled elsewhere in the US	Homemaker
4	2	M	Elders	Husband of above.	Retired professional
5	1	F	Midlife	Wife. Extended family. 3 generations coreside: elderly parents, adult children, young children.	Professional
5	2	M	Elders	Father of above. Same household	Retired professional
6	1	M	Midlife	Man, resides with wife and young children, elderly father lives in India	White collar
7	1	M	Midlife	Man, reside with wife and children, parents live elsewhere in the US	White collar
8	1	M	Midlife	Man, lives with wife and young children, parents in India with sibling	White collar
9	1	M	Midlife	Man, children grown and left home, parents in India	Blue collar
10	1	M	Elders	Man, Children grown and left home	Professional
11	1	F	Midlife	Woman, Children grown and left home, parents in India	White collar
12	1	F	Young adult	Woman, resides with husband and children, parents live with siblings in india	White collar
13	1	M	Midlife	Man, lives with teenage children. Elderly parents reside in India with siblings	Professional
13	2	F	Midlife	Wife of above, elderly mother has moved to the US and divides time between her and brother	Professional
14	1	F	Midlife	Woman, Elderly parents live in India with sister. She lives in the US with teen children.	Professional
15	1	M	Midlife	Man, Elderly parents, wife and children reside in India, they do not coreside. He lives and works alone in the US	Skilled trade
16	1	F	Midlife	Woman, lives with husband and children. Husband's parents reside in the neighborhood. Her own parents divide time between India, Canada, and visits to US.	Professional
17	1	M	Midlife	Man, lives with teen children. Elderly parents reside in another part of the US near his sister, but are planning to move to this area and coreside	Professional
17	2	F	Midlife	Wife of above. Her parents lived in India with a sibling, are now deceased.	Professional
18	1	F	Elder	Woman lives with her husband and young adult children, her mother is alive in India	White collar

We present the evidence that emerged from analyses of transcripts of midlife adults and seniors.

Midlife Adult Views

Elder Health Status Concerns

Because the participants were in midlife with elderly parents, parental health issues were among the first concerns that emerged in conversations, intertwined with views on where seniors should live. For example, most participants reported that their parents had degenerative or chronic health issues such as heart problems, diabetes, or arthritis, which dictated their lifestyle choices including moving to live with children.

One midlife woman whose older parents and parents in law were actively planning to immigrate to the US to live with their families said “My only concern is health. If one of my parents gets incapacitated, what will we do with two career families?” A midlife man described the factors that precipitated his parents’ decision to move to the US to live with him

“My parents were very reluctant ... but when my dad got suddenly very sick ... and my mother who was supposed to be the patient of the house had to switch roles and take care of my dad so that gave him a realization that what we are talking about made sense ... We had always discussed about this ... the actual decision to move was theirs ... but I think that these incidents may have given him some nudges.”

Most midlife participants felt it was their duty to help their parents immigrate to care for them. A midlife man said in a very typical statement:

“I have always been socialized that younger folks take care of the older generation. I have seen my mother do it and I have also taken care of my grandparents it seemed very obvious So what had happened was that when both the children had decided to settle in this country we were separated by distance and that created frustration. So we decided that it would be in the best interests for them to come here and it was family decision. ... We recently bought a house designed for that kind of care, it has a bedroom on the main floor.”

Health Care Affordability Concerns

Affording health care was a paramount issue for families of elders immigrating to the United States, and played a role in decisions on timing and destination of migration. This study was conducted prior to the 2010 Affordable Care Act. One midlife man said “I wish the US had some health insurance schemes we could buy, or partly government subsidized. Once parents cross age 70 or 75 it is very difficult to even get travelers’ insurance for them for a visit. If they could get insurance, then I could bring my parents here.” Another midlife man said about his parents:

“They would like to move here. But it may be too costly, because ... there is no insurance. In India they have health insurance, and pension, etc. ... If they could get insurance they would like to come here. ... My brothers are in UK ... It is easier for my parents to go to the UK. There they

have universal basic health coverage. My brothers have completed the UK immigration process for my parents, but they have not made actual plans to move.”

Community clinics and programs provided some health services for seniors. A midlife man said “for dental care I took my dad to the dental school” (which provides lower cost care). One midlife woman reported: “So if you look at their household income, my parents qualify for a program where they have very basic health insurance coverage from the county. They can see a doctor and get a prescription, they can get a flu shot, that kind of thing.” Basic doctor visits and bare bones preventive care was offered, but more complex tests, procedures, and prescription medications were not covered. As a result, families devised various strategies to access health care for their seniors. One strategy was to rely on networks of friends in the health care profession, as one midlife man described: “When he had some infection in his bladder so it had to be checked ... my brother ... found a urologist in LA who ... did it as a favor as he realized that my dad was not insured.” Another strategy was to invoke transnational networks and travel to India for some non-urgent aspects of medical care (e.g. vision care), or buy prescription medications for chronic conditions such as diabetes.

The midlife participants all had sufficient work history in the United States to qualify for Medicare for themselves, and several had additional retirement insurance benefits through their workplaces. Thus, the rising generation of Asian Indian immigrant seniors would not face the same concerns regarding access to health care in old age that their elderly parents faced, though new immigrants at any time would face them.

Immigrant Adjustment of Parents

Families of elderly immigrants also expressed feelings of loneliness, loss of independence and autonomy, and lack of daily occupation which the seniors had enjoyed in India. For example, a midlife man described his mother’s situation: “My elderly mother could not live alone, so the family got together and decided about her ... but she doesn’t want to live in the US, because when we go out she is all alone at home.”

Another midlife man reported: “The last time my father was here he didn’t like living here. He made like 4 or 5 visits to the United States, 6 months, 7 months, at a time but still ... In India every day he makes his plans, goes out for walks, goes every day to the temple, and other things. So my wife has returned to India to look after him.” Another participant described her parents who had decided to remain in India: “There they are quite independent. ... here they can’t handle the flight and the loneliness, there they really have a very active life. They don’t even miss their children.”

Despite this reluctance, other participants’ elder parents decided to immigrate to the US, because they wanted to be close to their children and grandchildren, and they had no extended family in India (e.g.: “My in-laws are moving here and we have plans to sell our house in India.”)

Coresidence and Intergenerational Relations

Though most midlife persons accepted that they would take care of their parents, most did not see themselves living with their children in their own old age. As one midlife woman put it: “No I don’t actually want to live with my children [laughs]. We’re hoping that we won’t need to. I don’t think we would want to live in the same house, but close enough so that if there is an emergency, they can help us.” Another said: “Nowadays even kids in India are not letting parents stay with them anymore. It used to be the case, but our children have grown up here, so I am not counting on it.”

Echoing a sentiment similar to the preference for ‘intimacy at a distance’ found in mainstream American families, another midlife woman said:

“I would like to stay close to children, not with them. Of course, I would like to be there for them and their kids like my parents have been there for me. ... It’s not that I will have any difficulty with them, but we can’t say what their circumstances will be. Also we all would like our privacy, and like to do things our own way.”

Another midlife woman, whose parents in law were in the process of moving in with her, expressed the same sentiment demonstrating adaptation to US culture:

“I will try to live away but near my children. We plan to have separate households. I am influenced by my American friends. You will retire and your children will have kids also, you will have privacy and independence and there will still be synergetic relations between you and your children.”

Almost all midlife participants expressed similar preferences. Only one midlife man said: “I will live with my sons, absolutely.”

Ambivalence in Intergenerational Relationships

Participants’ responses on coresidence led to discussion of positive and negative aspects of intergenerational relations in an extended family setting, indicative of psychological and social structural ambivalence in the context of immigration, and highlighting the nuances underlying the idealized picture of the Indian extended family.

Illustrating social structural ambivalence, a midlife man voiced specific doubts about care of elderly parents: “I have seen some who have come here in old age. Maybe their son or their daughter has called them here. But then ... The son or daughter feels that they have provided housing and all facilities for their parent so the parent should do something for them in return.”

Highlighting the structural gender differential within South Asian families, another midlife man described: “it’s very important for parents to be nice to their children. ... Everyone should be treated on the same footing, whether it’s a daughter or son ... how do they interact with people

living in the house, not just their son or grandchildren, but what about their daughter in law?" Corroborating this in the context of immigration, a midlife man reported

"There is a cultural difference in the way you run the family ... I don't think my parents or lot of their generation is used to seeing this. I have a lot of [male] friends in India who don't know how to cook or take care of children. There are things that traditionally men would do and in my house my wife does that. And there are some things women of the house do it but I do it. So I think when a parent sees this they sort of wonder."

Illustrating the psychological aspects of ambivalence in intergenerational relationships, other participants described their parents' intergenerational interactions and necessary adjustments. A midlife woman said: "My parents respect my brother's and my sister-in-law's privacy which is not a very Indian concept. ... For example, when my sister-in-law returns from work they both leave for their evening walk." Another midlife woman described some negative interactions and possibilities of difference of opinion: "There are bound to be issues, with the daughter in law, with children, or even with the son ... Seeing each other, bumping into each other all the time, that's not a good idea. It's not like in the olden days, where there were a lot of other interactions."

In the same vein, another midlife woman said:

"My mother does not like to live with my brother. She is a very strong and independent person and she likes to make decisions and I think that's not possible in someone else's house ... small things like she likes to watch TV all the time, but there are grandchildren studying for their exams, that will be constricting. In fact my parents felt the same way when they went to my sister's house."

Describing the compromises needed to negotiate inter-generational coresidential relationships successfully, one midlife woman remarked:

"My friends envy us when they see from the outside how all our family members are staying near each other. But I tell you it is not at all easy. It requires a lot of give and take and adjustment from everyone's side ... we have strong personalities. But we all know that we have to adjust with each other so we take care and do it."

Attitudes Toward Non-family Care

The conversations on care preferences revealed that midlife adults no longer preferred or expected their families to care for them. However, there was still no desire to receive institutional care. Rather than move to a care facility, participants would prefer to migrate back to India. One midlife participant said: "I would like to go back to India and stay by myself, where there are always other people around to help (relatives, neighbors etc.)". A midlife woman described her cultural expectations:

“I think when I can no longer take care of myself I would consider living in a rest home. Hopefully by then we will have a South Asian community home. Otherwise we would like to move to India ... we will have our Social Security but I don't think we will have our health insurance there.”

Another midlife man put it bluntly: “Not in an old age home! If it comes to that probably, then I would rather gather whatever money I have, and plan to go back and settle in India. If you save a bit of money, then the same amount of money will last longer there.” Most participants had not reached the life stage of making concrete plans for their own futures, beyond saving funds. None of them, for example, had researched retirement communities or made a deposit toward living in a long term care facility.

Older Adult Views

The older adults in our study included a couple who had immigrated at a younger age for work reasons, and others who had done so at an older age to join their children. Some coresided with extended family, others lived very near some family members and were in touch with other members elsewhere. Their views reflected some perspectives shared with those of midlife adults, along with some distinctive views. We present the evidence emerging from senior interviews for similar themes as from the interviews with midlife adults, and highlight differences in issues and interpretations where they arise.

Health Status Concerns

Many of the senior participants' health status included chronic conditions. A senior man said: “I have got diabetes and I want to exercise but somehow I cannot do regularly.” Another older man described how he had joint pains, but was much more absorbed in taking care of his wife who had a progressive health condition that was proceeding toward a terminal stage. He described “All her life, she took care of us, now though she is bedridden, it is not even feasible that we consider putting her in care elsewhere.” He further described how he and his family successfully navigated the Social Security Disability system to finance a part time caregiver for his wife “Even though we had not been in the country long [enough], somehow we had to make several appeals and they [the authorities] were very sympathetic toward us.”

Health Care Affordability Concerns

Affording health care was thus a concern for seniors, especially those who were not eligible for US programs such as Medicare. One senior couple described how they received basic care from a community clinic, which had a sliding scale of fees based on family income. Since they resided with a son who was the only earning member of the family, they qualified for subsidized primary care: “they keep our name in a category and whenever we want we can fix an appointment and go for treatment. We pay nominal. But if further examination is needed they recommend to the hospital and we go to the hospital, but we have to pay that.” Though she was concerned about the

cost, she was philosophical: “If that case arises I am not worried about it ... think about god ... You have to put full efforts into god’s name and everything will proceed and go well.”

A senior woman who was Medicare eligible shared: “We are well taken care of by Medicare. The health care system is not a problem but affording a medical insurance is a problem ... People can’t afford health care. If you go to a doctor they charge really high here. Health insurance costs are going up.”

Immigrant Adjustment

Older adult participants, reflecting the fact that they had made the decision to immigrate, appreciated many aspects of life in the United States. For example, an older man said: “so many things are so well organized here ... everything is convenient.” Another older woman reflected mixed views: “I am with my children and I feel happy. But I miss cultural things like music and all.” She described how she kept herself busy to adjust: “I keep busy ... children’s weekly language class, daily kitchen work, taking care of [grand]children ... In the winter season I sometimes do the knitting. I switch work in whatever sequence I want to do.” Yet another participant reflected on her counterparts decision: “They came here but they are more attached to India. They have property there ... they like it there ... but their three sons are here so they are planning to come back.”

Another older woman, who had immigrated as a younger adult to the US along with her husband and young children, described the process of adjusting to a new country, specifically different ways of interacting with others, was difficult but essential:

“It took me a long time to become a citizen ... because I always felt I belong to India. Then I realized that after living here for so many years ... you are more American than Indian. Because you learn soon that you call somebody before going ... Back in India ... nobody would call and come they would just drop by ... Here people understand that it is not nice to bother somebody and take their time. Time means something, time means value here. So then you come to know that if people just knock on your door you resent it and this is not Americanism, it is you! So then you just think about yourself and laugh.”

Co-residence and Intergenerational Relations

In contrast to midlife adults, most senior participants preferred to rely on family care when they could no longer live alone. Co residence of seniors with their adult children is socially normative in South Asian populations, in the form of ‘joint families’, as extended families are termed in Indian communities. Older persons (compared to midlife) expressed more preference for joint family living, typified by an older woman’s statement: “The Indian concept is for parents to live with the son”. Another older man said: “the joint family system in India is an outstanding one and I admire it ... it gives insurance and lot of happiness for elders.” Another older woman said “we should always take care of our family. That’s how things should be.”

Another pattern was for elderly parents to spend some time living with each different child, to maximize family interaction and minimize the pressure on any one child. Participants described how formerly, it would be taken for granted that elderly parents would live with their sons, but nowadays seniors were open to living with their daughters. An older woman, not currently residing with her children, said “not in the older days [i.e. people used to not prefer to live with their daughters]. But now there is no restriction. Any child can look after their parents.” When requested to clarify which of her children she would prefer to live with, and how the decision would be made, she responded “It happens that one child may move to one place, another to another place. So we will have to shift around based on convenience.”

Different family members might live in different countries, and some participants traveled among the countries as circumstances needed. One older couple for example divided their time between India and the United States making family visits, maintaining immigration status in the US, and accessing health care and looking after finances in India. They described relatives who had joined their children in Canada due to the universal health care available there, who divided their time between Canada, other children in the US, and family visits in India. Many participants mentioned such transnational strategies to maintain family links and facilitate health care.

Ambivalence in Intergenerational Relationships

In contrast to the midlife generation, older adults were less expressive about the positives and negatives, or the ambivalence, of joint family coresidence and intergenerational relations. This was not because they took a uniformly positive view of coresidence, but that they viewed coresidence and mutual adjustment as normative. An older man described the situation tersely: “There are pluses and minuses”. Another explained, illustrating psychological ambivalence “Always there is some difference of opinion and both parties have got to yield and everything will be ironed out.”

A woman described the process of adjustment in intergenerational relations and coresidence in idealized terms:

“Every individual should forgive and forget and give and take ... Ego they should remove from their heart. ... of course we will do whatever the children say because after all our duty is to make our children happy so whatever they say we will do. ... Individual cases are there where they may have problems ... but you should live as a good example.”

An older man described his experience, illustrating the social structural ambivalence that arose when he could not express his opinion on his grandchildren’s daily routines “My daughter does not like it if I tell them not to watch so much TV, we must all compromise so it is better for me not to say anything”. As a senior male, he might have expected his views would be regarded, but being a member of an immigrant family in the US living with his children and grandchildren, he had to adjust.

Another older man, who did not currently coreside with his US-raised children (but had not ruled it out for the future), framed the issue in terms of adjusting to life in America “Of course, disagreements are there like in any family ... it is your choice how Americanized you want to be ... but it slowly seeps into your life. ... We have loosened up a bit, you learn a lot of things from them [the children] ... their heritage is different.” That is, he felt that seniors’ accepting children’s different lifestyles in the US was essential for harmonious family relationships.

Attitudes Toward Non Family Care

None of the seniors wanted to live in a retirement community, a rest home, or any type of extra-familial setting, due to perceived lack of cultural fit, and to preference for family living. The participants did not distinguish among the different types of senior living facilities (e.g. nursing home, board and care home, continuing care home, etc.), but viewed them all under the heading of “rest home” or “nursing home”. An older man said: “Considering a rest home, the difficulty for us would be adjusting to the food and culture, for us those would be really hard things.”

An older woman said: “I have never considered the possibility ... it is very hard to put out your hand in front of someone else”, suggesting that to her way of thinking, receiving non familial care was equivalent to acknowledging that the family could not take care of its own needs, but needed charity from others.

Community Needs for Elder Support

Information emerging from the interviews suggested gaps in service design and delivery for ethnically diverse older populations. Several senior services were not considered useful by the participants in our study. Programs such as Meals on Wheels were not familiar to our middle class sample, and when described, they felt that the types of food served would be culturally unacceptable. Similarly, mainstream senior centers were less used by this group. Most of the older participants preferred to join community specific cultural groups (e.g. a Tamil or Telugu community groups), some of which have formed senior associations for social activities.

Most of the senior participants were in sufficiently good health to not need daily assistance. When asked what types of programs they envisioned as most useful for them and others like them, the most common response was “Health care needs should be properly addressed” or “They [the government] should make some arrangement for health insurance. There is nothing we can do about it.”

At the time of research, almost none of the participants had heard of end of life care plans such as Advance Directives and thus had not considered or completed such documentation. When probed, most seniors had not thought about making their wishes for end of life care known to their families or explicitly documented. Most envisioned a “good death” (e.g. Walter 2003) as one that occurred naturally, without suffering or prolonged medical intervention, surrounded by

family. Most older participants views echoed that of one older woman, who said “I am not worried about it. Whatever happens I will be happy.”

Emotional support was expressed as a major need for seniors in the community, including additional avenues for socialization. Instrumental support, particularly transportation, is also of major importance. A midlife man stated:

“People have money, but because of the demands of society, children seem money-minded and neglect their parents ... the ethnic community should come together and organize their own programs for seniors to socialize and spend time together. For example, in Phoenix, South Asian employees of one corporation have joined together and formed an informal support group for all their parents. They take it in turns, and organize activities, transportation, escorts for long distance travel, etc.”

Thus, the suggestion is that impetus to develop culturally customized programs should come from within the community, in partnership with mainstream organizations and state agencies. As another participant expressed “From the policy perspective it would help our workers because these senior care issues cause stresses and strains which take them away from work.”

Discussion

Our results suggest that South Asian immigrant seniors preferred family care, meaning intergenerational coresidence. We analyzed intergenerational relationships through the theoretical lens of ambivalence, which we argue is a very applicable framework for the joint (extended) families normative in South Asian cultures. Though coresidence suggests a major dimension of intergenerational solidarity (Silverstein and Bengtson 1997), living together necessitates mutual adjustment to inherent social structural and psychological contradictions, especially among immigrant families in the United States. Seniors’ views on positive and negative aspects of intergenerational relationships among families living together or in very close proximity, echo aspects of social structural and psychological ambivalence observed in intergenerational relationships in Western societies (Connidis and McMullin 2002; Luescher and Pillemer 1998). These dimensions have been less explored among minority and immigrant/transnational populations, or in other global settings. Our study provided evidence on ambivalence in an Indian community, in the context of immigration. Other studies (e.g. Kalavar and Van Willigen 2006) also interviewed older Indian immigrants on the benefits, challenges, and nuances of multi-generational coresidence, without however considering the theoretical concept of ambivalence. Our findings support theirs in that while seniors acknowledge the pluses and minuses of coresidence, they still prefer to reside with family.

The midlife participants in our study were in favor of caring for and living with their parents, but did not want to live with their children in old age themselves. They prefer close family input and relationships, a situation described as “intimacy at a distance” in the United States. This finding accords with similar changes over generations noted among other Asian immigrant seniors

(Liu 2003; Diwan et al. 2011). The midlife generation discussed in-depth aspects of ambivalence in intergenerational coresidence. Due to these aspects, they did not want or expect to live with their own children for care. More studies exploring how ambivalent relationships present in diverse populations, and how these relate to choices in care and health service use, are needed.

Health issues were an important factor for seniors to immigrate to join their adult children, but they faced barriers because of the limited health insurance offered to immigrants without a US work history, in contrast to countries with universal health care coverage. All our participants mentioned health care access and costs as a primary concern. Immigrant seniors without a US work history are not Medicare eligible, and those who immigrated after the PRWORA “Welfare Reform” legislation of 1996, are not eligible for Medicaid, until they have been US citizens for 5 years. The process of acquiring US citizenship can itself take 2 to 3 years, and eligibility to begin the process starts only after immigrants have held a green card for 5 years or more. This is a long time to be without a safety net, and private insurance providers offer very limited and expensive coverage for older adult immigrants. Community health services offer limited support for senior primary health care. The Affordable Care Act (2010) was passed after our interviews were conducted, but follow up conversations with some participants indicated that families of immigrant seniors are becoming aware of some relevant provisions (e.g. insurance exchanges) for uninsured persons though information is still new. At the time of writing, most of the main features of the legislation have been upheld by the US Supreme Court, however many uncertainties remain in its implementation and political future in various states.

Our study participants fit the description of ‘transnational families’, with close family members living in more than one country. They traveled periodically between countries, for reasons including escaping harsh weather, family visits, seeking health care, managing finances, retaining eligibility for status, etc. Prior research on transnational families focused more on care chains for children, but older adults are now a significant part of the issue, particularly in South Asian extended families (Aggarwal and Das Gupta 2013; Victor et al. 2012). Transnational family relationships and caregiving engage not only the intra-familial context, but also a macro framework of citizenship, social welfare benefit structures, and economic issues. With the lack of universal health care coverage in the United States, transnational families mobilize networks for health care access. In Canada or the United Kingdom, which have health care access for all citizens these networks are mainly for cultural and social capital (Patel 2011; Victor et al. 2012). More research is needed on how the macro contexts mutually engage with family relationships, in influencing care choices of seniors in transnational families.

Midlife participants, most of whom had entered the US as young adults, have a US work history and thus qualify for Social Security, Medicare, and other retirement health insurance benefits. Thus, access to and affordability of health care are not major concerns for them. However, their wish to exit the United States after retirement to live in a culturally more familiar environment, is balanced with the fact that Medicare and health insurance benefits are not portable outside the country, though Social Security can be carried overseas. Neither generation welcomed the notion

of living in a rest home or any other institution in the United States, largely due to perceived poor cultural fit. This accords with Diwan et al. (2011), but is in contrast to studies showing that some older Japanese women immigrants to the US prefer formal care to overburdening their families (Kawakami and Kronenfeld 2012).

At the time of interviewing, our study participants also did not use other senior services, including senior centers (other than as a meeting space for the senior associations of South Asian cultural subgroups) or Meals on Wheels. This may reflect the nature of our participant group, which is more educated and middle class and has sufficient family resources to live without assistance. The experience of one family whose elder had a severe and terminal health condition indicated that culturally competent home care aides would have been perceived as useful, but the family was grateful to receive any services. Our findings on preferred coresidence of immigrant seniors underscores Kuo and Torres-Gil's (2001) recommendation that culturally appropriate services for Asian immigrant seniors be designed and delivered within a family context, with discussion and communication to ascertain different members' preferences and role in decision making. Providers often ignore the needs of older Asians, assuming that the community prefers to take care of its own members, an extension of the model minority myth which has left many Asian groups' needs under-served (Nandan 2007). The development and availability of culturally competent services would help members of immigrant communities who do not have resources for self sufficiency. Moreover, many older South Asians are recipients of SSI and may also need senior services other than what their families can provide (Lamb 2002). Older immigrants use SSI at greater rates than native born elders, and, due to changing intergenerational relations and differences between expectations and ability regarding care, seniors may prefer not to live with their children (Lee and Angel 2002).

Differing male and female perspectives on caregiving issues are important for Asian families (Chappell and Kusch 2007). However, participants in this study mentioned few differences in expectations of care between sons and daughters, and midlife adults of both genders described a commitment to taking care of parents. One of the midlife adult children did briefly mention that daughters in law might be treated differently than daughters, but an older participant stated that daughters and sons could look after parents nowadays. Thus, a detailed examination of gendered perspectives and expectations on caregiving are beyond our current scope and should be explored in future research.

Our study has several gaps. Our participants are rather homogenous in terms of their socio-economic background. We could not document many aspects of participants' intergenerational relations, health status, or other factors, in greater detail. We also could not deeply examine gender differences in caregiving. We also conducted the interviews over a time frame of a few months and could not follow them over a longer time frame to observe additional aspects of migration decisions, residential choices, or intergenerational relations. Moreover, all the seniors were community dwelling, and we were not able to locate any facility-dwelling Asian Indian seniors to interview at that time. However, this study adds to the growing evidence on

intergenerational relations in an immigrant community and the implications for preferences for elder care, which can contribute to future research.

Policy and Program Suggestions

Study participants suggested several measures that could be considered by planners and policy makers to improve services for older immigrant adults.

1. Accessible and affordable health insurance for immigrant seniors who are not eligible for Medicare or Medicaid was the most pressing need voiced by this community. Though the Asian Indian participants in this study were relatively self-sufficient, the health coverage of the working age adults extends to their dependent children, not to their parents. Immigrant seniors are a very vulnerable segment of the population, since they are ineligible for Medicare, are less likely to be able to find affordable insurance on the private market, and cannot qualify for Medicaid until they have held US citizenship for 5 years (a process which itself takes several years). Some relief may be offered by certain provisions of the 2010 Affordable Care Act (Kenney and Huntress 2012), though details are still emerging at the time of writing.
2. Participants stressed a need for culturally customized senior services, including home based care services. While most seniors relied on family networks to meet their needs, there was potential for the burden to grow greater in coming years, while service provision lagged in meeting the needs.
3. The development of a culturally and linguistically competent senior care work force is a priority to assist the growing number of minority seniors in the United States. The situation of South Asian seniors is complicated by the existence of multiple languages, religions, and sub cultures within this group. However, workers can gain exposure to and expertise with specific sub groups and build a client base.
4. Asian Indian midlife and senior participants seemed less aware of existing services, until a significant need arose. Though there have been some senior-targeted outreach and awareness programs conducted by cultural organizations, much more remains to be done in this area. Awareness of appropriate financial planning, health care planning, and advance directives all need to be improved. Therefore, portals of information for appropriate senior services should be better publicized, organized, and culturally customized if needed.

5. Asian Indian seniors often participate in religious activities. Thus, religious institutions and organizations need to increase outreach and program awareness activities for seniors. There are some emerging developments in this arena as some cultural subgroups within the Asian Indian community have started senior wings. However, this effort is still emergent and needs to be developed further, with co-operation from existing mainstream organizations and service agencies.

These recommendations parallel those found in other studies of immigrant seniors (Bhattacharya and Shibusawa 2009). Others (Blair 2012) suggest involving immigrant seniors in a Community Advocate Program for Seniors: CAPS, an innovative hybrid of family-community worker, to link South Asian clients and service providers.

Conclusion

In conclusion, our qualitative study interviewed midlife and older Asian Indian adults in North Carolina, investigating ambivalence in intergenerational relations and views on elder care. Results suggest that the older generation continues to consider family care of elders to be normative and desirable. The midlife generation favors providing this care for seniors, but does not desire or expect the same from their own children for themselves, preferring to remain comparatively independent, but still maintain communication and co-operation. The interviews also suggested aspects of social structural and psychological ambivalence in intergenerational relationships, in the context of immigrant Asian Indian extended family settings in the United States. Access to health insurance was a major concern for transnational older adults in the United States, due to lack of eligibility for most existing programs and benefits, and lack of universal health care coverage. Suggestions and recommendations for policy and program development also emerged, including improved health insurance coverage, the development of a care provider work force more aware of cultural diversity, the design and delivery of culturally customized services tailored to a family setting, and increased co-ordination of community organizations and agencies serving elders in order to increase community awareness on elder issues, needs, and programs. Future studies should expand the examination of the role of gender issues in care, intergenerational ambivalence in ethnically diverse and immigrant populations, and how these relations may affect preferences for elder care. In addition, studies should focus on how the health care policy climate in the US affects family decisions on elder migration.

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