UNDERSTANDING THE ROLE OF CULTURE IN THE HEALTH-RELATED BEHAVIORS

OF OLDER ASIAN INDIAN IMMIGRANTS

by

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(Under the Direction of Sharan B. Merriam)

ABSTRACT

The purpose of this study was to understand how cultural values influence health-related behaviors among older Asian Indian immigrants in the United States. To achieve this purpose, the following questions guided this research: 1) How do older Asian Indian immigrants learn about health-related issues? 2) In what ways do culture and heritage affect older Asian Indian immigrants' health behaviors? and 3) How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches?

A qualitative research approach was employed. In-depth interviews were conducted with eleven participants to obtain data on how cultural values shape the health-related behaviors of older Asian Indian immigrants. A purposeful sampling was conducted to find suitable participants. All participants were at least 60 years of age and had moved to the U.S. as adults. Neither they nor any immediate family member was involved in healthcare professions. Eight men and three women representing various regions of India were interviewed using in-depth interviews with open-ended questions.

Analysis revealed five key resources the participants used to learn about health. These included their healthcare professional, immediate family, the Indian community, media, and the

Internet. An analysis of the findings also addressed three cultural values that influenced these immigrants' health behaviors. First, the participants worked to establish a personal relationship with their healthcare professional. Second, there was a high level of family involvement not only during the treatment process, but also in the everyday maintenance of health. And third, these immigrants value alternative medicine, making it a viable option when these individuals are faced with an illness. Finally, analysis of the last set of findings highlighted the participants' decision making process when they are considering medical treatment. Data indicated that these immigrants experiment with both Western and Eastern medicine and their belief in traditional systems of healing cause them to be skeptical of certain Western medical practices.

Based on the findings the following conclusions were drawn from the study: Indian culture and heritage shape healthcare behaviors of older Asian Indian immigrants and informal learning is the primary way these immigrants learn about health.

INDEX WORDS: Adult Education, Adult Learning, Informal Learning, Health Education, Asian Indians, Immigrant Healthcare

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DEDICATION

To Sandy, my golden, who has shown me the true meaning of unconditional love and taught me the value of taking time to "stop and smell the roses."

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CHAPTER 1

INTRODUCTION

As healthcare improves in the United States and across the world, people are living

longer. In 1970, it was estimated there were 307 million people in the world over the age of 60.

There were 500 million in 2000 and in 2020 it is estimated there will be one billion (Bee, 2000).

Worldwide, the number of people in this age bracket is growing faster than any other age group

(World Health Organization [WHO], 2002). Within the United States, persons aged 65 years or

older currently represent approximately 13% of the population (Administration on Aging, 2001).

This proportion is expected to increase to more than 20% by the year 2010 when the baby

boomer generation begins to enter the older age period (Kim & Merriam, 2004). These older

adults are the most frequent users of medical services. For example, chronic diseases become a

burden for nearly 40% of the older adult population, often leading to a diminished quality of life

(National Center for Chronic Disease Prevention and Health Promotion, 2002).

Not only are the numbers of older adults increasing, but the composition of this segment

of the population is also changing. Immigration is one factor affecting the makeup of the elderly

in the United States. Additionally, immigration to the United States continues to increase each

year. For instance, the Administration on Aging (2005) reports that members of minority groups

are projected to increase from 5.7 million in 2000 (16.4% of the elderly population) to 8.1

million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly).

As these first-generation immigrants begin to age, their need for health services will begin to

magnify. For this reason, it becomes imperative to gain an understanding of how these groups

interact and utilize health services in the United States. Thus, the goal of this study was to better understand how Asian Indian cultural values shape how these immigrants learn and navigate their healthcare in the United States.

Asian and Pacific Islanders and Healthcare

Asian and Pacific Islander Americans (APIAs) have been the fastest growing ethnic minority population in the United States over the past 20 years. In 1970, the number of APIAs was 1.4 million; in 1980, 3.5 million; and in 1990, 7.3 million (U.S. Bureau of the Census, 2000). By 1992, it was estimated that the APIA population had numbered 3.3 percent of the total population, and these numbers are expected to quadruple by 2038. By the year 2050, American Pacific Islander Americans will exceed 41 million and constitute 10.7 percent of the total U.S. population (U.S. Bureau of the Census, 2000).

This broad category of immigrants comprises about 32 different national and ethnic groups (Austin & Prendergast, 1994). The distribution of Asians in the United States is as follows: Chinese (23.8%); Filipino (18.3%); Asian Indian (16.2%); Vietnamese (10.9%); Korean (10.5%); Japanese (7.8%); Cambodian (1.8%); Hmong (1.7%); Lao (1.6%); Pakistani (1.5%); Thai (1.1%); and other (4.7%) (U.S. Bureau of the Census, 2000). Since the majority of these immigrants are foreign born, strong cultural values, beliefs, and traditional health practices are still evident in their behaviors. These are reflected in unfamiliarity with Western concepts and terminology of illnesses and diseases, as well as with modern diagnostic techniques or treatments. Lack of understanding of the U.S. healthcare system prevents them from utilizing available services or following prescribed treatment (Ma, 1999). Additionally, many Asian Americans may also be apprehensive about seeking medical help from Western doctors or practitioners and, as a result, may withhold or avoid disclosing information about their cultural

practices. Thus, the lack of culturally competent services becomes a major obstacle for provision of services to Asian patients, and a challenge to healthcare providers. Because the U.S. healthcare system often fails to recognize indigenous medicine and other traditional health practices common among Asian immigrants, these patients are often hesitant to cooperate with their respective providers.

As the APIA population continues to grow in the United States, researchers have begun to explore the implications for this group in regard to healthcare, as well as health behaviors. For example, Grewal, Bottorff, and Hilton (2005) examined the influence of family members on immigrant South Asian women's health and health-seeking behaviors in order to better understand how these women made decisions regarding their health. In-depth interviews revealed that these participants made decisions about their health in consultation with family members, who were often perceived to be supportive and provided direct and indirect assistance to women in ways that influence their health. In addition, it was evident that expected roles and responsibilities often had detrimental influences on women's health. This type of information is critical for healthcare professionals in order to reach these individuals effectively. By taking into account women's relationships with family, as well as their influence on women's health, both physicians and educators can better serve the needs of this group and improve their health-seeking behaviors.

In addition to shaping health behaviors, culture also plays a role in learning. This relationship has been widely studied in the fields of both multicultural education as well as adult education. Most often, culture has been treated as a factor, along with others that influence the learning behaviors of a particular group of people. However, culture is not merely a minor factor or an issue that is related to a particular group of people. Every person embodies and represents

his or her own culture. As DuPraw and Axner (1997) maintained, culture is central to what we see, how we make sense of what we see, and how we express ourselves. Anthropologists Avruch and Black (1993) emphasized that culture provides the "lens" through which we view the world, the "logic" by which we order it, and the "grammar" by which it makes sense. As a social and cultural being, an adult is shaped and constrained in every aspect of his or her life.

Culture is a popular yet ambiguous concept in our language system. Different people use different layers of meaning to describe culture. Kroeber and Kluckhohn (1952) summarized more than 160 definitions of culture, explicitly reflecting the complexity of this term. Banks and Banks (1997) offered a well recognized definition, stating that culture is "the values, symbols, interpretations, and perspectives that distinguish one group of people from another in modernized societies" (p. 8). Still others believe that the essential element of culture is values. According to Hofstede (1980), values refer to "a broad tendency to prefer certain states of affairs over others" (p. 19). Cultural values have served as a standard to judge situations, to interpret meaning, or to direct people's daily behaviors.

A number of empirical studies reveal the important role of cultural values in shaping the learning process of adults from non-Western backgrounds (Alfred, 2003; Hvitfeldt, 1986; Merriam & Muhammad, 2000). For instance, Hvitfeldt (1986) provided an earlier qualitative study that explored the relationships between learning behaviors and cultural values in adult education. After observing an American basic education classroom for newly immigrated Hmong people (a minority group from Southeast Asia), Hvitfeldt found that Hmong adults' learning behaviors, such as reliance on external sources, achievement as group cooperation, and a holistic rather than analytic perceptual style, significantly reflected their community life in preliterate and pre-technical society. Similarily, in their study on learning activities of older

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Malaysian adults, Merriam and Muhammad (2000) found that Eastern cultural values, such as collectivism, hierarchy, and relationship orientation, shaped the way these individuals learned.

The above discussion illustrates the importance of cultural values in shaping both health and learning behaviors. However, much still remains unknown on specific groups within Asian and Pacific Islander Americans, and specifically the intersection of learning and health-related behaviors. For this reason, researchers have begun to investigate the various subgroups among the APIA population independently in order to better understand and appreciate the unique characteristics of each ethnicity (Ma, 1999; Lin-Fu, 1993). However, there are still some groups that remain overlooked, even though their presence within the United States continues to increase.

<div align="center">Asian Indian Cultural Values and Healthcare</div>

According to the 2000 U.S. Census, there are over 1.5 million Asian Indians residing in the United States, representing the third largest APIA group after Chinese and Filipino. Furthermore, this population had the highest compound growth rate of all Asian subgroups at 7.49% per year from 1990 to 2000. Even more specifically, it has been argued that Asian Indians are one of the fastest growing elderly groups in the United States (Doorenbos, 2003). However, little is known about these immigrants and how their culture shapes the way that they learn about health. Asian Indian immigrants, just like other minorities, are a heterogeneous group, representing a huge mosaic of cultures, and people of widely varying socioeconomic status, education, place of residence, generation, views, values, lifestyles, and appearance. However, this population has an added complexity in that they also do not share the same language. Although the national language is Hindi, only about 40% of Asian Indians are fluent and use this language on a daily basis (Shapiro, 2001). Instead, there are a plethora of dialects

that are dependent upon the region of India from which an individual comes. This variance in communication creates a type of "segregation" within the community, as people tend to socialize and interact with those individuals who share a common language other than English.

Though this diversity does make it increasingly difficult to examine this population, commonalities still exist across Asian Indian subgroups. When considering healthcare, belief in traditional medicine still exists within these communities, especially among elders. One specific approach is called Ayurvedic medicine, which focuses on obtaining balance, not only physically, but also mentally and spiritually. This system of medicine emphasizes treatment of the complete human being and not just physical disorders. When a person becomes unbalanced, Ayurveda practitioners will recommend specific lifestyle and nutritional guidelines to assist the individual in regaining equilibrium. Herbal supplements may also be suggested to hasten this healing process.

The use of alternative medicine continues to grow every year, and with this increased interest, researchers have begun to develop additional terms for these types of medical systems, such as parallel therapies or dual systems. This movement away from "alternative medicine" indicates the understanding that Western and Eastern medicine is not necessarily in conflict with one another, but working together, these systems can actually increase the effectiveness of treatment. Whether one identifies the approach as alternative, parallel, or another similar term, the fact remains that its use is growing. For instance, Channa (2004) estimated that two-thirds of the world's population seek healthcare from traditional, indigenous systems of medicine such as Ayurveda. Within the past decade, these types of alternative practices have permeated the United States healthcare systems as well (Ruggle, 2005). Barnes, Powell-Griner, McFann, & Nahin (2004) surveyed 31,044 people, with 36% responding that they had used a form of

alternative therapy, such as -meditation, yoga, and/or diet-based therapies (which are all components of Ayurvedic medicine) over a one year period. Major medical journals are publishing research on the efficacy of specific alternative therapies, physicians are attending oversubscribed continuing medical education courses on this issue, and hospitals are offering alternative services, sometimes through outpatient integrative medicine clinics. Ruggle (2005) argues that this increase in interest among the U.S. medical system can be traced to numerous factors, from an increase in alternative therapy use, governmental support, a surge in scientific research, to a rise in physicians' interest in this area.

While a large number of individuals in India continue to rely solely on Ayurvedic practices (Ariff, 2006), here in the United States the focus is on integrative medicine, where there is collaboration among the primary healthcare provider, the specialist of alternative care, and the patient (Barrett, 1993). This new form of treatment is especially beneficial for chronic illnesses such as arthritis, hypertension, and asthma, which are common in older people and are often accompanied by symptoms that are not easily eradicated by conventional medicine. Additionally, because of the frustration with conventional medical practices, many individuals are choosing to take more personal responsibility for their health by exploring a variety of self-regulatory, mind/body, and wellness practices independent of their physician's input. These often include techniques such as meditation, which are considered alternative by U.S. medical standards (Barrett, 1993). However, as the population continues to age, it can be argued that more individuals will begin to seek alternative remedies that offer an increasingly holistic approach to treatment. Therefore, understanding these practices among Asian Indian immigrants can not only help us to better serve the needs of this population, but also expand alternative medical services for the U.S. as a whole.

In addition to indigenous medical practices, religion also plays a role in shaping the health decisions of Asian Indian immigrants. Although there is not one unifying faith for all Asian Indians, approximately 82% of this population is Hindu (Takaki, 1995). Hinduism is not only a religion, but also a way of life, providing its followers with cultural values and guiding principles for behavior and interaction with others. For instance, in the Asian Indian community, elders are revered and should be treated with the utmost respect. This belief sets up a hierarchy within familial relationships, which is represented in the language itself (Roland, 1988). Different terms distinguish between aunts and uncles, older and younger brothers and sisters, as well as maternal and paternal relatives. This structure affects communication among Asian Indians as well as with others. Within this system, the roles of individuals are defined according to age, sex, and status. Docility, respect for authority, and restraint of strong feelings are encouraged, while direct expression of thoughts are discouraged (Pai & Adler, 2001). This emphasis on authority has the potential to impact the doctor-patient relationship. Due to the importance of hierarchy, Asian Indian immigrants may defer judgment to their physician because they believe that he or she is the expert on medical issues. These individuals may not readily voice their concerns during the consultation, making it necessary for the healthcare professional to prompt this type of information. This probing is especially critical with these individuals because they may be practicing a number of alternate approaches that could impact the negotiation of the healthcare process.

Although it may appear that the hierarchical structure hinders the formation of relationships, the extended family is still essential and serves as a unified support system. These immigrants are accustomed to solving problems and making decisions with friends and family. For instance, Asian Indians not only prefer to include family members in the treatment process,

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but may even defer decision making to other individuals in their network. These individuals like to consult with friends and family when seeking information and making decisions, as this network serves as social support. This reliance on relationships, both within the family and among the community, can provide many informal learning opportunities for these immigrants.

Indeed, informal learning characterizes the majority of learning in adult life. When considering informal learning, which is usually intentional but not highly structured, it helps to contrast this concept with formal learning to better understand its subtleties and nuances. Marsick and Watkins (1990) offer the following definition:

> Formal learning is typically instutionally sponsored, classroom-based, and highly structured. Informal learning…may occur in institutions, but it is not typically classroom-based or highly structured, and control of learning rests primarily in the hands of the learner….Informal learning can be deliberately encouraged by an organization or it can take place despite an environment not highly conducive to learning. (p. 12)

More specifically, informal learning can be characterized as integrated with daily routines and triggered by an internal or external jolt. Additionally, this type of learning process is often influenced by chance and is linked to the learning of others (Marsick & Volpe, 1999).

Networking, a form of informal learning, is popular among groups who value community, such as Asian Indians. Networking is a type of shared learning, where individuals work together to locate information and find solutions. Learning opportunities flow from the communication that creates the linkages between individuals and clusters of people. This type of knowledge acquisition is quite common among Asian Indians. Since this community is so interwoven, it can be considered a network within itself. People often come together to celebrate

cultural holidays and festivals, and these gatherings become avenues for communicating information. Individuals share their stories and experiences, making conversations the means for learning. This is evident even with health issues, as a large number of Asian Indians still attend health fairs to gain knowledge about diseases and other medical concerns. A number of physicians and other healthcare professionals from the Indian community come together, offering exams, answering questions, and providing support. In a way, these fairs serve as a health network for these immigrants, where learning is the result of a dialogue with a number of people within the community.

English (2000) also noted that the characteristics of informal learning provide a spiritual component not necessarily available from other more traditional teaching methods. Because this form of learning occurs continuously in the everyday world, it stimulates reflection on people's actions. Furthermore, informal learning not only supports individual learning, but also provides an opportunity to explore group development. By building from pre-existing relationships, individuals feel a sense of community and belonging, a factor that is more important than individual growth for Asian Indians. The spiritual nature that can result from the relationships created during the mentoring and networking process is also beneficial and motivating to these immigrants. This population's views on learning and development are much more holistic than the Western approach. Asian Indians seek to nurture the mind, body, *and* soul, and the various methods within informal learning offer these individuals the flexibility to not only focus on intellect, but also the spirit.

The literature suggests that informal learning offers an alternative to more traditional forms of learning that would be highly conducive for Asian Indian immigrants. Networking and

the spiritual nature of informal learning allow these individuals to learn and build community at the same time.

<div align="center">Statement of the Problem</div>

In today's society, life expectancy continues to increase as advances in technology continue to encourage the development and implementation of new medical treatments and solutions. For example, within the United States, persons over age 65 currently represent approximately 13% of the population (Bee, 2000). As the baby boomer generation enters retirement, this number will continue to increase. In addition to this growth, the rise in immigration continues to change the demographics within the United States., thus impacting the composition of the elderly population. As individuals within these minority populations age, their use of health services will continue to increase.

Although there has been a wide array of research concerning minorities and healthcare, knowledge on the Asian Indian community is limited, even though this is one of the fastest growing elderly groups in the United States (Doorenbos, 2003). Asian Indian philosophy offers an alternative perspective to the Western viewpoint and these differences influence how these individuals learn and interact with others. These immigrants value family and maintaining relationships and much of their learning takes place within and among the community in an informal setting. Furthermore, these distinctions become increasingly evident when exploring traditional Asian Indian health practices, such as Ayurvedic medicine, which focuses on treating the mind, body, *and* spirit. Understanding these nuances is critical to serving the needs of this growing population. However, very little research explores how these cultural values impact the way in which these immigrants learn about health in the United States. For this reason, it is

imperative to have a better understanding of how cultural values shape Asian Indians' behaviors and approaches to health.

Purpose of the Study

The purpose of this study was to understand how cultural values influence health-related behaviors among older Asian Indian immigrants in the United States. Specifically, I examined the following:

1. How do older Asian Indian immigrants learn about health-related issues?

2. In what ways do culture and heritage affect older Asian Indian immigrants' health behaviors?

3. How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches?

Significance of Study

This study adds to multiple knowledge bases in a variety of ways, highlighting a population, namely Asian Indian immigrants who are continually overlooked, despite their growing numbers in this country. By exploring how their cultural values shape their health behaviors, it is possible to better understand different aspects of these immigrants. For instance, this research adds to the adult learning literature by illuminating how these individuals learn and negotiate health issues. While there is a considerable amount of literature on informal learning, there is very little on how Asian Indian immigrants utilize this form of knowledge acquisition in everyday life, and more specifically, when dealing with health related issues. This study helps to expand the concept of informal learning.

In addition to further developing the concept of informal learning, this research also provides practical applications for health practitioners, as well as health educators. By investigating these immigrants, this study highlights a number of key cultural values that not

only impact their learning process, but also the way that these individuals approach health. Understanding these nuances is critical in order to effectively treat these immigrants, especially as the number of elderly among this population continues to grow. This information becomes invaluable as more and more Asian Indian immigrants begin to utilize health services within the United States. Health professionals will be better able to reach this population when they understand the connections between cultural values, behavior, and learning.

As immigrant populations continue to grow in the United States, the impact of cultural differences is becoming recognized. Among health professionals, the need to be increasingly sensitive to other cultures and their beliefs are coming to the forefront and is referred to as cultural competency (Sue, Ivey and Pedersen, 1996). This study helps to expand on this notion by illustrating a number of core Asian Indian cultural values, an element that is currently missing from the literature in this area. These characteristics are not only beneficial for physicians in a clinical setting, but also for instructors and planners as they develop outreach programs for this population.

Finally, this research illustrates the value of alternate ways of knowing, specifically foregoing the dichotomy between mind and body and approaching learning from an increasingly holistic perspective. This contrast is magnified when dealing with health issues, because Western medicine often treats symptoms and has a tendency to neglect the spiritual component that is so highly valued among Asian Indians. By investigating the negotiation process that these immigrants utilize when confronted with an illness, these individuals demonstrate the importance of understanding and treating the *whole* person rather than just the body.

Definitions

The following definition is important for this study:

Culture is the sum total ways of living; including values, beliefs, esthetic standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication which a group of people has developed to assure its survival in a particular physical and human environment (Chryssochoou, 2004). It is learned behavior, beliefs and attitudes; simply stated, it is all human activities obtained by learning (Wissler, 1929) which are largely invisible yet always present sources of authority in people's lives (Bowers, 1993, p. 21).

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study was to explore how Asian Indian cultural values shape the health-related behaviors of older Asian Indian immigrants living in the United States. The research questions that guided this study were: (a) How do older Asian Indian immigrants learn about health-related issues? (b) In what ways does culture and heritage affect older Asian Indian immigrants' health behaviors? and (c) How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches? With this in mind, this chapter explores the following four bodies of literature in order to situate this study: cultural issues in education, Asian Indian cultural values, informal learning, and immigrant healthcare.

Learning and Culture

Learning is always situated within a cultural setting. Individuals select from information in the culture's information pool, refashion, recreate, invent, and synthesize the resulting data into a structure of knowledge (Barkow, 1989). Culture can then be considered a "map" that can help guide the learning process. Though it is not possible to know all the details of either our own or another people's cultural map, an understanding of the general terrains of the society's culture will be helpful in relating to others and designing effective teaching-learning situations (Pai & Adler, 2001).

While it is evident that culture affects the learning process, educational endeavors also have the ability to influence how people think, believe, judge, and act. Mullins (1999) discussed the concept of learning across cultures, noting that educators seek to understand and be

understood by students who are members of other cultures. She further argues that for this process to occur, individuals need to not only be willing to share their own experiences, but also remain open to hearing the opinions of others. Instructors can create supporting learning environments that will help foster this type of dialogue. By sharing personal values and beliefs, individuals can learn about the world through an alternate lens and identify issues and possible solutions in new and unique ways. Through this process, students are able to engage in critical thinking which can not only highlight, but also alter cultural assumptions.

The relationship between culture and learning is an important topic and has begun to enter the dialogue in the field of adult education. According to McLoughlin (1999), "culture and learning are interwoven and inseparable" (p. 232). As a social being, everyone lives in his or her own culture. DuPraw and Axner (1997) maintained that culture is central to what we see, how we make sense of what we see, and how we express ourselves. Hofstede (1991) expressed similar ideas and believes that culture is so fundamental that "no part of our lives is exempt from culture's influence" (p. 170). Guy (1999) also maintained that every aspect of adult life is shaped by culture, and he further points out that education has served as a vehicle for defining cultural values that people hold or that they view as central to being successful in their society. Based on their extensive research on learning styles, Dunn and Griggs (1995) conclude that each cultural group tends to have some learning style elements that distinguish it from other groups. The following section examines cultural issues specifically within the field of adult education.

Two well-known theories of adult learning – andragogy and self-directed learning – can be examined to demonstrate the link between learning and culture. Andragogy was known to be the first theory created for adult learning. Knowles (1980) defined it as the art and science of helping adults to learn in an attempt to make a distinction from pedagogy (the education of

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children). His five assumptions reveal characteristics of adult learners: 1) As people mature, they become more self-directed; 2) Their life experiences are valuable resources for learning; 3) Their learning becomes oriented to the development of their social roles; 4) They wish to apply knowledge immediately, and 5) Their learning orientations shift from subject centered to problem centered. Similarly, Pratt (1991) critically assessed the underlying cultural assumptions of Malcolm Knowles' andragogy theory:

> This particular view of adult education espouses, at least implicitly, a set of beliefs about the nature of adults as learners, motives for learning, appropriate types of relationship[s] between teachers and learners, and the nature and role of self-concept within the educational process. Its proclaimed goals are the "democratization" of education and the empowerment of the individual; and its methods of collaboration and choice are coupled with a profound appreciation of individual differences. This is embedded within a cultural commitment to individual autonomy and the right to choose as central values to be protected and promoted. Thus, it is no accident that such a conception of adult education, as a set of beliefs and a way of practice, has taken root and flourished in the soil of Jeffersonian democracy. The strident individualism of the United States, with its constitutional proclamation of individual rights, has indeed been fertile ground for such growth. (p. 303).

Self-directed learning, another theory, focuses on the learning process itself and includes a series of concepts by different researchers (Knowles, 1975; Grow, 1991, 1994). It advocates that learning occurs as a daily part of adults' lives. Self-directed learning is systematic, self-planned and self-realized, and leaves control with the learner.

Andragogy, self-directed learning, and a number of other key learning theories have helped to articulate the characteristics of adult learners and provided insights into the learning process of adults. However, these major adult learning theories have also been criticized for being developed from mainstream culture – the white, male, and Western European culture (Amstutz, 1999; Lee, 2003; Pratt, 1991). Caffarella and Merriam (2000) analyzed the long tradition and historical focus on individual learners in adult education, noting that many key theories assume that learning happens "primarily internally" (p. 56) regardless of the situation and background of the learners.

Amstutz (1999) further critiqued the cultural limitation of traditional adult learning theories, nothing that these frameworks are acontextual. Furthermore, she argues that these theories are highly individualistic, attempting to define knowledge as a generalizable truth for all cultures, thus "making the assumption that the 'right' way to know things is acceptable only through one hegemonic filter" (p. 19). Lee (2003) also evaluated adult learning theories, specifically focusing on andragogy from the perspective of an immigrant learner, noting its inattention to the roles of the historical and socio-cultural context of diverse learners, as well as for the overgeneralization of characteristics of the privileged group to most adults in American society.

Echoing these theoretical critiques, other empirical studies have further revealed how socio-cultural background affects people's learning processes and outcomes. In an earlier study, Hvitfeldt (1986) observed an American basic education class for newly immigrated Hmong adults and found that their learning behaviors are significantly influenced by their preliterate and pre-technical culture and reflected their interdependent community life. In the classroom, they show a respectful and submissive attitude toward the instructors, rely on external referents,

achieve tasks through group cooperation, and demonstrate a holistic rather than analytic perceptual style.

Pratt (1990, 1991, 1992) conducted several studies on Chinese adult teachers and learners. He found that learning for Chinese individuals was understood as the acquisition of knowledge or skills from others, a fulfillment of responsibility to society, and a change in understanding of external matters and oneself, while teaching was recognized as the delivery of content, the development of character, and a type of relationship. Pratt believed that these concepts are compatible with the cultural, social, political, and economic context of mainland China. In a similar fashion, Merriam and Muhammad (2000) performed a study on the learning activities of older Malaysian adults. They found that these individuals' learning was significantly shaped by Eastern cultural values such as collectivism, hierarchy, and relationship orientation. For example, learning was seen as "a highly social activity where they [learners] enjoyed being in a group and relating to other learners" (p. 59). In addition, Malaysian older adults view learning "as a responsibility and a means of giving back to their communities" (p. 60). This emphasis on community and service clearly reflects the collective and interdependent culture of Eastern society.

Alfred (2003) explored the learning experiences of Anglophone Caribbean immigrant women in postsecondary institutions through qualitative inquiry. Serving as both researcher and participant, Alfred interviewed 15 individuals in order to better understand how culture shaped the way these immigrant women learn. The findings of this study revealed that culture and early schooling socialization in their country of origin have significantly influenced these adult immigrants' learning experiences in the United States. Having assimilated indigenous knowledge from their families and local communities, as well as having been socialized in the

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teacher-directed and selective British education system, these women became silent knowers who preferred learning through lectures and written exercises rather than learning from dialogue and active classroom participation. To voice their opinions, challenge the authority of instructors, and participate in discussion were contradictory to their silent learning style, and thus created a learning challenge for these women.

The examination of cultural assumptions and limitations of adult learning theories and exploration of the role of socio-cultural context in its influence of the learning processes of adult learners from different societies helps to not only extend our understanding of the learning process, but also expands the horizon of adult education research. Many researchers have begun to consider culture as an important contextual factor that influences adult learning. Guy (1999) points out that the idea of a generic adult learner with certain universal characteristics and traits has been gradually rejected by most researchers in adult education and that socio-cultural context strongly influences the motivations, needs, goals, and perspectives of the learners during their learning process. For this reason, it becomes imperative to have a clear understanding of culture, cultural values, as well as its implications for learning and other health-related behaviors.

<center>Cultural Values and Asian Indian Cultural Values</center>

Culture is a complex concept that has been defined by many people in a variety of ways. There is little consensus on one single definition. Anything commonly shared by a group of people and distinguishing them from other groups – such as food, clothes, music, art, language, and customs – can be labeled as culture. Kroeber and Kluckhohn (1952) once summarized more than 160 definitions of culture, underscoring the broad range of this concept. The multi-layered and non-static nature of culture was best described by Vinken, Soeters, and Ester (2004) in their statement that "culture is conceptualized as a phenomenon lacking coherence, full of

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complexities, something that is dynamic, continuously changeable, and fundamentally fluid" (p. 6). In the following section, I will first explore the definitions of culture and cultural values. Following, I will review some major studies on cultural values and conclude by highlighting some key characteristics of Asian Indian culture.

Definitions of Culture

While the term culture first appeared in an English dictionary in the 1920s (Kroeber, 1949), the first use in an anthropological work was by Edward Taylor (1871), who defined culture as "that complex whole which includes knowledge, belief, art, morals, laws, customs, and many other capabilities and habits acquired by man [sic] as a member of society" (cited in Berry, Poortinga, Segall, & Dasen, 1992, p. 165). Two rather short but now widely used definitions were later proposed: Linton (1936) suggested that culture means "the total social heredity of mankind" (p. 78), and Herskovits (1948) said that "Culture is the man-made [sic] part of the human environment" (p. 17). In contrast to these concise definitions, others sought to create lengthy lists of what was included in the term culture. For instance, Wissler (1923) included speech, material traits, art, knowledge, religion, society, property, government, and war (cited in Berry, Poortinga, Segall, & Dasen, 1992).

As the number of definitions grew, researchers began to seek methods to organize the plethora of meanings. In a classic survey, Kroeber and Kluckhohn (1952) suggested that there are six major classes of definition of culture to be found in the anthropological literature: descriptive, structural, historical, normative, genetic, and psychological. Descriptive definitions are those that attempt to list any and all aspects of human life and activity thought by the writer to be an example of what one means by culture. Both Taylor's and Wissler's definitions, which were expressed earlier, serve as examples of this type of classification. For Kroeber and

Kluchhohn (1952), this category stresses the widespread totality of culture. Similarly, structural definitions underline the pattern or organization of culture. However, this category requires going beyond the obvious features in order to discover preexisting arrangements. The central view here is that culture is not a mere list or assortment of customs, but forms an integrated pattern of interrelated features (Berry, Poortinga, Segall, & Dasen, 1992). Historical definitions, such as Linton's, tend to highlight the accumulation of tradition over time rather than specifying the entirety or range of cultural phenomena. The term heritage is frequently used in these definitions, as well as the term heredity, but the context clearly indicates that no biological factors are thought to be involved in this growth. Unlike descriptive and historical definitions, where the cultural life being referred to is clearly observable, normative definitions require us to dig into the explicit activity and to try to discover what lies behind it. This category underscores the shared rules that regulate the events of a group of people.

Rather than focusing on the elements of culture, genetic definitions focus on the origin of this phenomenon. Within this category there are three main answers given: culture arises as adaptive to the habitat of group, out of social interaction, and out of a creative process that is a characteristic of the human species. Finally, psychological definitions take an increasingly broad approach in explaining culture, considering aspects such as adjustment, problem solving, learning, and habits (Berry, Poortinga, Segall, & Dasen, 1992). This classification stresses that culture is a learned phenomenon, a factor that is of particular interest to educators and will be discussed in greater detail shortly.

Although it has been argued that culture originated in anthropological studies, as the concept grew and expanded, a rather large number of other disciplines have begun to research this phenomenon. For instance, scientists refer to culture as a way to understand the differences

between societies. Still others speak of music, art, and travel as representing culture. The list of definitions is extensive and continues to grow as an increasing number of individuals seek to understand the nuances of culture. A more recent definition of culture by Banks and Banks (1997) demonstrates that people focus more and more on the internal essence rather than the external expression of culture:

> The essence of a culture is not its artifacts, tools, or other tangible cultural elements, but how the members of the group interact, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies. (p. 8)

This definition is reminiscent of that of Kroeber and Kluckhohn (1952) in indicating that the values are the core or important components of a cultural system. By examining the above definitions and categorizations, we can summarize the main features of culture. First, culture is a shared symbolic or meaning system. Second, culture is formed through a rather long period and passed from generation to generation. Third, culture "glues" a group of people together and directs their ways of living and behaving in a similar way. Fourth, culture distinguishes one group of people from another. And finally, values represent the core of a culture.

This concept of values has been explored and expanded further by several researchers. Values are seen as relatively fundamental compared to rituals, heroes, and symbols. According to Hofstede (1991), a value is "a broad tendency to prefer certain states of affairs over others" (p. 8). In other words, values represent how things "ought to be" according to an individual or group. For this reason, values influence and shape behavior.

Classic Studies on Cultural Values

How cultural values shape people's daily lives and behaviors is a significant question that many anthropologists and cross-culture researchers have explored. Kluchhohn and Strodtbeck's (1961) well-known research increased awareness of the taken-for-granted cultural values that are subtly embedded and learned during childhood. These authors studied five culturally distinct communities in the Southwestern United States in order to illustrate the impact of culture on the differences in value orientations. Through this research, Kluchhohn and Strodtbeck identified five problems common to most cultural communities and possible responses to each of these issues:

1. What is man's [sic] assessment of human nature? [Evil, neutral, good-and-evil, or good]

2. What is man's [sic] relation to nature? [Subjugation-to-nature, harmony-with-nature, or mastery-over-nature]

3. What is the temporal focus of life? [Past as tradition-bound, present as situational, or future as goal-oriented]

4. What is the group's principal mode of activity? [Being, caring little about achievement, being in becoming, stressing inner development, or doing as emphasizing material success]

5. What is the modality of the group's relationship to others? [Authoritarian mode, group-oriented, or individuals] (p. 453)

These five questions focus on the five main aspects of people's lives: human nature, the person-nature relationship, time orientation, mode of activity, and social relationship. It is hypothesized that different cultural groups will have different answers to some or all five inquiries. For

instance, Mexican American communities tend to be present-oriented and group-oriented, which is in sharp contrast with the future orientation and individualism emphasized in European American communities. Similarly, the value of being in harmony with nature is stressed in Asian communities, while European Americans' prefer a master-over-nature mindset (Ortuno, 1991).

The most influential research on national cultures was conducted by Hofstede (1980, 1984, 1991), a Dutch scholar who was active in a broad range of social science disciplines. Through a survey study on work-related values of over 100,000 employees of a large company operating in 40 countries, he developed five dimensions from a factor analysis of cultural averages: 1) individualism/collectivism, 2) power distance, 3) uncertainty avoidance, 4) masculinity/femininity, and 5) long/short term orientation. In individualistic cultures, such as the United States, people tend to perceive themselves as individuals rather than as part of a group, whereas in collectivistic cultures, such as India, people see themselves as members of a group and give higher priority to the interests of the community. Power distance refers to how a society accepts unequal power distribution. In high-power distance cultures, power differences and social hierarchies are accepted, valued, and honored. Uncertainty avoidance refers to the negative reaction to ambiguous or risky situations. Individuals in cultures with high uncertainty avoidance are more hesitant to take risks, change, or accept new ideas. The concepts of masculinity and femininity consider a culture's orientation to gender and whether they are viewed as distinct or overlapping in roles and definition. Finally, long/short-term orientation focuses on the concept of time. Long-term orientation stands for fostering of virtues which emphasize future rewards such as perseverance and thrift. In contrast, short-term orientation

stresses qualities related to the past and the present, particularly respect for tradition and fulfilling social obligations.

Another series of representative studies on multicultural values were carried out by Schwartz and her colleagues (1987, 1990, 1994). Schwartz, an Israeli social and cross-cultural psychologist, views culture as a complex, multidimensional structure, with values at the core. She defines values as "the criteria people use to select and justify actions and to evaluate people (including the self) and events" (Schwartz, 1992, p. 1). By reviewing previous work and developing a theoretical map of the value domain, Schwartz identified seven culture-level value types. *Conservatism* is a value that emphasizes the status quo, propriety, and encourages the avoidance of actions or inclinations that have the ability to agitate others. *Intellectual and affective autonomy* focuses on the individual being in control of his or her own destiny and goals. *Hierarchy* is a value that accepts power differentials and resource allocation. *Mastery* encourages developing confidence with the social environment through self-assertion. *Egalitarian commitment* values the well-being of others and individual's commitment to promote this form of welfare. Similarly, *harmony* also endorses the notion of community service. But, in addition to social welfare, this value also encourages unity with nature.

Rather than searching for the common and fundamental elements of diverse national cultures, Hall (1976) divided cultures into two categories: low context and high context. Individuals within a low-context culture tend to use direct verbal expression style that underscores situational context, explicitness, self-expression, verbal fluency, eloquent speech, and vocal expression of one's opinion. In contrast, people in high-context cultures often use an indirect verbal expression style that places less emphasis on explicit verbal messages, rely heavily on contextual cues in conveying important information, value harmony, use ambiguous

language and silence in interactions, and avoid saying no directly. According to Hall (1976), low-context cultures include the United States, Canada, the United Kingdom, Germany, Australia, most of Western Europe, and Scandinavia. Typical high-context cultures include Japan, China, Korea, Latin America, the Mediterranean, the Middle East, Vietnam, and most of France.

Although many cross-cultural researchers have identified the huge cultural differences between the East and the West, the former is usually represented by Chinese culture. While there are similarities among all Asian perspectives, more importantly, there are unique differences between China and India that shape learning and health. The following section highlights specific Asian Indian values.

Asian Indian Cultural Values

Culture can be viewed as consisting of standards and control mechanisms with which members of a society assign meanings, values and significance to things, events, and behaviors. These mechanisms are the products of human beings' unique ability to symbolize, or to originate, determine, and bestow meaning upon things and activities in the external world and the ability to understand these meanings (Pai & Adler, 2001). This helps to explain how the same item or event can have alternate meanings for different people. For example, in India, the cow is considered sacred because it is believed that this animal is a reincarnate of God. For this reason, the cow is not consumed as food. Similarly, a specific river located in north India is considered to be holy. Thousands of individuals pilgrimage to this place every year to bathe in its waters. It is thought that this river has spiritual powers, as its water is given to people as they are dying and many have their ashes spread in this sacred place. However, both of these examples are

especially significant for Asian Indians. This indicates that the meanings of objects, events, and behavioral patterns need to be understood and appreciated within their specific cultural context.

In addition to assigning meaning and importance to activities and objects, culture also dictates the norms of a society. A norm is a "should" or "ought", a prescriptive statement of how people expect others to behave in a particular situation (Barkow, 1989). For instance, in the Asian Indian community, elders are supposed to be treated with the utmost respect, and this is indicated by a specific greeting. Norms also refer to how one is "supposed to" behave in a particular society and cover things such as what to eat, what to wear and where, whom to marry and how to court, as well as how to worship. Within the Indian community, dating is still not readily accepted and arranged marriages still continue today. There is a tremendous amount of faith in family and it is believed that relatives have the ability to choose an appropriate mate. At the wedding, there is certain attire and specific colors that are deemed suitable and deviation is unacceptable. Familial and communal relationships existing in harmony are valued above the individual (Merriam & Muhammad, 2000), and maintaining and nurturing these relationships is critical.

Although it may appear that this type of structure hinders the formation of relationships, the extended family is still essential and serves as a unified support system, even among Indian immigrants. This emphasis on the collective can make the American saying "You have to look out for yourself because no one else will" difficult to comprehend and disheartening. These immigrants are accustomed to solving problems and making decisions with friends and family. This preference for cooperative learning should be considered when communicating with this population. For instance, although Western medical practices privilege doctor-patient privacy, when working with Asian Indians, it is important to involve family members in the treatment

process. These individuals like to consult with friends and family when seeking information and making decisions, as this network serves as social support.

This hierarchical structure also affects communication among Asian Indians as well as with others. Within this system, the roles of individuals are defined according to age, sex, and status. Further, individuals are expected to deal with problems indirectly so as not to offend others. Docility, respect for authority, and restraint of strong feelings are encouraged, while direct expression of feelings and thoughts is highly discouraged (Pai & Adler, 2001). It is important to recognize that communication flows from higher to lower positions in the hierarchy. This affects the learning environment, especially in a traditional classroom. These individuals will be less likely to voice their opinions, because they have a tremendous amount of respect for the teacher and consider his or her knowledge highly valuable. This emphasis on authority extends into other relationships as well, and is evident between physicians and patients. Although Asian Indians confer with family and friends about their treatment processes, there is a strong possibility that they will defer judgment to their doctor because they believe that he or she is the expert on medical issues. For this reason, they may not readily voice their concerns during the consultation, making it necessary for physicians to prompt this type of information. This probing is especially critical with these individuals because they may be practicing a number of alternate approaches that could impact the negotiation of the healthcare process.

In addition to emphasizing family relationships and respect for authority, there is also a difference in the conception of time. Western societies are increasingly future-oriented, focusing on tomorrow and the implications that the new day brings. In contrast, Indians concentrate on the present, giving value to the moment at hand (Roland, 1988). This belief is spiritual in nature and is reflected in this community's concept of well-being. For example, yoga is a popular

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practice that incorporates meditation and reflection and focuses on self-actualization by helping

individuals eliminate mental, emotional and other such distractions. By focusing their energy on

the present, Asian Indians seek to unite the mind, body, and spirit, providing them with a holistic

view of their identity. A number of the alternate medical approaches that are used by Asian

Indians incorporate these ideas of spiritual well-being. For instance, it is believed that

homeopathic medicine increases the vitality, or life force, that animates each of us. If we weaken

and deplete our vitality (as suppressive therapies do), we diminish our immune function, thereby

becoming increasingly susceptible to all disease — physical, emotional, as well as mental. The

goal of homeopathy is to simulate the body's own healing capacity, so that it corrects these

imbalances and weaknesses that allow disease to emerge. This approach is believed to stimulate

an accelerated immune system response, release underlying energetic blocks and trauma

imprints, provide a non-toxic, safe and natural system of healing, complement orthodox

allopathic medicine if necessary, revitalize all levels of being, raise vitality, and assist in healing

the body/mind/spiritual connection. Hinduism stresses holistic development over material well-

being (Merriam & Mohamad, 2000), and thus Asian Indians are continually searching for

methods to merge the mind, body, and spirit.

  Our cultural values are evident in the experiences that we share everyday. Jerome Bruner

(1996) discussed the importance of stories and their affect on the construction of reality. Each of

our narratives is situated within a cultural context, and this becomes magnified for immigrants as

they attempt to navigate between two distinct environments. I cannot help but think about my

own acculturation process, being Asian Indian, but being raised in an American society. I can

vividly recollect the tales that my parents and grandparents shared to help me understand my

heritage, as well as my cultural beliefs – the importance of family and education, my role as a

daughter, sister, and wife, and my obligations as a human being. Each of these stories served as

a building block, as I learned (and continue to learn) how to mold these values into a Western

context. In addition to emphasizing cultural values, these narratives also serve as texts, which

allow these individuals to informally learn from everyday situations.

Informal Learning

The process of acquiring knowledge by adults can be realized through formal, non-formal

and a spectrum of informal and incidental learning (Coombs, Prosser, & Ahmed, 1973; Merriam

& Brockett, 1997; Merriam & Caffarella, 1999). The three forms of learning (Galbraith, 1992;

Merriam & Brockett, 1997; Merriam & Caffarella, 1999) have characteristics that serve as

indicators to learners who want to choose how to further their knowledge base to satisfy their

needs. Formal learning is structured usually by a single or a collaboration of entities and is held

in an educational institution, often granting some type of credentials such as a diploma,

certificate, or degree (Galbraith, 1992; Merriam & Caffarella, 1999). The learner has little

control over what is taught and the method(s) in which the information will be presented. The

major responsibility of curriculum development lies with educators who structure learning

programs that will provide necessary content to satisfy educational pursuits (Galbraith, 1992). In

formal settings, teachers often have some form of professional training that provides credibility.

Learning pursuits outside of formal settings (educational institutions) are recognized as

nonformal. Nonformal learning refers to organized activities that take place sometimes outside

of educational institutions but are located in community-based settings, such as local churches,

cooperative extension, or non-profit organizations (Galbraith, 1992; Merriam & Brockett, 1997;

Merriam & Caffarella, 1999). Organizations having education as part of their mission often

conduct educational programs in communities in order to combat barriers such as transportation

and work schedules. Learners have some control over what they learn, as well as when, how, and where this learning will take place (Galbraith, 1992).

Informal learning is probably one of the most frequently discussed aspects of adult education. Some researchers say that as much as 70 percent of learning takes place outside classrooms and formal education institutions (Day, 1998). Various terms have been used for it, including experiential learning, nonformal learning, and incidental learning. For example, Fenwick (2000) prefers the term "experiential learning" to refer to adult learning that is situated in everyday undertakings, whether it happens at work, in the home, or in the community. She offers five currents of thought that have become prominent in discussing experiential learning within the adult education literature: reflection, interference, participation, resistance, and co-emergence (Fenwick, 2000). She describes reflection as a process where the learner reflects on lived experience and then interprets and generalizes this experience to form mental structures. Born out of constructivism, it is believed that the learner constructs meaning by reflecting on his or her actions. The idea of interference focuses on an individual's relations between the outside world of culture and objects of knowledge and the inside world of psychic energies and dilemmas of relating to these objects of knowledge. Our desires and resistances for different objects, which we experience as matters of love and hate, attach our internal selves to the external social world (Fenwick, 2000). This viewpoint seeks to build on this form of anxiety between the conscious and unconscious mind to generate knowledge, and more importantly, self-understanding.

In contrast, Fenwick (2000) described an alternative learning perspective which she calls participation. This approach is similar to situated cognition, where learning is rooted in the situation in which a person participates, not in the head of that person as intellectual concepts

produced by reflection nor as inner energies produced by the psychic conflicts described in interference. Knowing and learning are defined as engaging in changing processes of human activity in a particular community. Knowledge is not a substance to be ingested and then transferred to new situation but, instead, part of the very process of participation in the immediate situation. Similarly, Lave and Wagner (1991) noted that individuals learn as they participate by interacting with the community (with its history, assumptions and cultural values, rules, and patterns of relationship), the tools at hand (including objects, technology, languages, and images), and the moment's activity, along with its purposes, norms, and practical challenges (cited in Fenwick, 2000).

Although participation emphasizes interactions among individuals within a community, Fenwick (2000) argued that this approach overlooks power relations that inevitably exist when people communicate and work together. For this reason, she explores a concept called resistance, which emerges from the critical cultural perspective, where there is a focus on understanding and analyzing existing structures of dominance within a given society. By recognizing such oppressions, it becomes possible to resist such forces, thus allowing people to become open to unexpected, unimagined possibilities for work, life, and development. Through this form of understanding, Learning becomes about critical awareness about one's contexts as well as one's own contradictory investments and implications in what knowledge counts in particular communities, how development is measured, who gets to judge whom and why, and the interests that are served by resistant or development initiatives.

Finally, co-emergence portrays experiential learning in an ecological way by emphasizing processes of self-organization and interdependence which occur through feedback loops. For this reason, this perspective considers understandings to be embedded in conduct,

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drawing attention to the background by examining myriad fluctuations, subtle interactions, imaginings and intuitions, the invisible implied by the visible, and the series of consequences emerging from any single action (Fenwick, 2000). Here the focus is not on the components of experience (which other perspectives might describe in fragmented terms such as person, experience, tools, community, and activity) but on the relationships binding them together in complex systems. Learning is thus cast as continuous invention and exploration produced through the relations among consciousness, identity, action and interaction, and objects and structural dynamics of complex systems.

Some of these viewpoints consider the learner to be at the center of the learning transaction, some see the context as the key ingredient, and some view the relationship between learner and context as the catalyst for learning. No matter where an individual is on the continuum, the fact remains that much of adult learning takes place outside formal institutions.

At least one author defines informal learning by what it is not: learning determined or designed by an organization (Day, 1998). Some authors use these different terms to indicate slight variations in the process that takes place. For the purpose of this study, however, informal learning is considered to be learning that takes place outside formal instruction, and it may take place without any conscious decision to learn on the part of the learner. Informal learning may occur in the context of work, family relationships, community involvement, religious participation, or leisure pursuits.

Informal learning is often afforded "residual" status, representing the entire collection of adult knowledge that is gained outside formal contexts. Cairns (2000) however insisted that the process is much more complex. She suggests that the ever-changing nature of adults' lives, their social contexts, and their individual needs and choices create layers of learning that interact with

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all of the above elements. Not only did Cairns (2000) suggest that the majority of what people learn over their lifetime occurs informally, she argued that what is learned through this method may be the most significant learning that an individual acquires.

The context in which informal learning occurs is also the focus of studies conducted by English (1999, 2000). She suggests that this form of learning is generally unintended, and it happens on a continuum of learner consciousness (English, 1999). Additionally, she asserts that informal learning takes place continuously in every context (English, 2000). In her study of parishioners adjusting to changes in church leadership, participants reported that their learning was affected by such elements as incidents of change, the church context, action required of parishioners, and extraordinary circumstances (English, 1999). Furthermore, it was noted in this study that, perhaps like all informal learning, "for learning to occur, there has to be some element of reflection on action" (English, 1999, p. 391). She also found that it was not always easy for church members to articulate their informal learning, which may be an additional feature of informal learning that bears investigation.

In addition to being difficult to articulate, another complexity of informal learning is that it is difficult to measure, both in participation and in knowledge and skills gained (Gorard, Fevre, & Rees, 1999). Gorard et al. use informal learning to indicate a deliberate act on the part of a learner, but without taking part in a course or training activity. They also include learning that goes on in work and leisure situations, and they believe that much of the learning that goes on in work is so difficult to measure that it escapes notice of employers and researchers alike (Gorard, Fevre, & Rees, 1999). If informal learning is difficult to measure, it may be even more difficult to describe. This study discovered that women were less likely than men to describe their activities as "learning," even when it was apparent that significant learning took place.

An element of control in informal learning is one of the features that make it attractive to adults (Garrison, 1997). The desire to be in control of making decisions regarding what to learn, how to learn it, and when to learn it, appeals to most adults' sense of autonomy. More researchers agree that adults have an innate desire to learn, and they want to direct the course of how that learning takes place (Garrison, 1997). Additionally, Garrison (1997) stated that "motivation to assume responsibility in learning is influenced by external conditions and internal states" (p. 29). This may help to explain why some adults seek out self-directed learning opportunities and others do not. The grouping of external conditions and internal states may not be balanced for some individuals. This same combination of factors may also explain why some adults tend to engage in leisure pursuits, whether participating in a number of actvities or becoming involved in a particular one for a very long time.

When describing informal learning, if is often helpful to imagine a continuum, with formal learning on one end and informal on the other (Stein, 2001). However, this process is increasingly complex, because there is no concrete dividing line between formal and informal learning and there are numerous times when these two styles merge. The term natural learning, developed by Watkins and Marsick (1992), is also used to identify learning from experience that takes place outside formally structured, institutionally sponsored, classroom-based activities. This approach is often composed of incremental learning, also known as "filling in the gaps" (Burton & Perkins, 2003). Many different activities are used to gain knowledge, from reading to lectures to collaborative inquiry. This last method is popular among groups who value community relationships. The community is where adults spend the majority of their time interacting, learning, as well as acquiring and improving knowledge in order to meet their needs. Galbraith (1992) noted that informal learning is characterized by interactions and can occur in a

variety of situations such as informal debates and conversations in the work, family, or community setting, leisure-time activities, as well as listening to audio cassettes, reading publications, or viewing video tapes.

Networking is another example of informal learning and involves learning through widespread relationships. Learning opportunities flow from the communication that creates the linkages between individuals and clusters of people. This type of knowledge acquisition is quite common among Asian Indians. Since this community is so interwoven, it can be considered a network within itself. People often come together to celebrate cultural holidays and festivals, and these gatherings become avenues for communicating information. Individuals share their stories and experiences, making conversations the means for learning. This is evident even with health issues, as a large number of Asian Indians still attend health fairs to gain knowledge about diseases and other medical concerns. A number of physicians and other healthcare professionals from the Indian community come together, offering exams, answering questions, and providing support. In a way, these fairs serve as a health network for these immigrants. Although this interaction is planned, it can be argued that the learning is still informal because it is the result of a dialogue with a number of people within the community.

It has also been noted that the characteristics of informal learning provide a spiritual component not necessarily available from other more traditional teaching methods. Because this form of learning occurs continuously in the everyday world, it stimulates reflection on people's actions. English (2000) argued that informal learning is experienced best when learners depend upon one another and draw strength from personal connections. Furthermore, this interaction not only supports individual learning, but also provides an opportunity to explore group development, which is critical when working with Asian Indians. By building from pre-existing

relationships, individuals feel a sense of community and belonging, a factor that is more important than individual growth. The spiritual nature that can result from the relationships created during the networking process is also beneficial and motivating to these immigrants. This population's views on learning and development are much more holistic than the Western approach. Asian Indians seek to nurture the mind, body, *and* soul, and the various methods within informal learning offer these individuals the flexibility to not only focus on intellect, but also the spirit.

<div align="center">Immigrant Healthcare</div>

Asian and Pacific Islander Americans (APIAs) represent the fastest growing ethnic minority populations in the United States over the past twenty years, increasing from 1.4 million in 1970 to 7.3 million in 1990 (U.S. Bureau of the Census, 2000). This growth is projected to increase, with the Bureau of the Census estimating that APIAs will double their current size by 2009, triple by 2024, and quadruple by 2038. By the year 2050, APIAs will exceed 41 million and constitute 10.7 percent of the total U.S. population (Lin-Fu, 1993).

In addition to this growth, Asian and Pacific Islander Americans represent a culturally and ethnically diverse group differing in language, socioeconomic status, as well as patterns of immigration. The APIA population is comprised of about thirty-two different national and ethnic groups (Austin & Prendergast, 1994) including Chinese, Filipino, Japanese, Asian Indian, Korean, Vietnamese, Hawaiian, Lao, Cambodian, Thai, Hmong, Samoan, Guamanian, and Tongan (Ma, 1999). This distribution highlights the heterogeneity of the APIAs and illustrates the difficulty in examining this group.

Though this population possesses a large amount of diversity in regards to customs, culture, and religion, they still share a number of barriers that prevent them from seeking and/or

receiving adequate healthcare. Research shows that this population has limited access to healthcare, and hence has a lower health status, attributed mainly to language, cultural, socioeconomic, and other systemic barriers (Association of Asian Pacific Community Health Organizations, 1995). Other barriers are self-imposed. For example, many APIAs often avoid biomedical treatment or other formal health service utilization, preferring traditional and ethnic healthcare, exposing themselves unnecessarily to preventable health conditions.

Because the majority of Asian Pacific Islanders in the United States are foreign-born, strong cultural values, beliefs, and traditional health practices are still evident in their behaviors. These are reflected in unfamiliarity with Western concepts and terminology of illnesses and diseases, and with modern diagnostic techniques or treatments. Lack of understanding of the U.S. healthcare system prevents them from utilizing available services or following prescribed treatment (Ma, 1999). Additionally, many Asian Americans may also be apprehensive about seeking medical help from Western doctors or practioners and, as a result, may withhold or avoid disclosing information about their cultural practices. Thus, the lack of culturally competent services becomes a major obstacle for provision of services to Asian patients, and a challenge to healthcare providers. Because the U.S. healthcare system often fails to recognize ethnomedicine and other traditional health practices common among Asian immigrants, these patients are often hesitant to cooperate with their respective providers.

Language is yet another barrier that APAIs face when confronting the healthcare system in the United States. In 1990, 4.5 million people reported speaking at least one APAI language at home, and 2.4 million of these reported that they did not speak English very well (Ma, 1999). Today, the U.S. healthcare delivery system is still unprepared to respond to these groups' linguistic needs. Clinics and hospitals serving them often do not have interpreter services,

leaving the burden of assuring communication entirely to service consumers (Brooks et al., 2000).

As the APAI population continues to grow in the United States, researchers have begun to explore the implications for these groups in regard to healthcare, as well as health behaviors. For example, Grewal, Bottorff, and Hilton (2005) examined the influence of family members on immigrant South Asian women's health and health-seeking behaviors in order to better understand how these women made decisions regarding their health. In-depth interviews revealed that these participants made decisions about their health in consultation with family members, who were often perceived to be supportive and provided direct and indirect assistance to women in ways that influenced their health. In addition, it was evident that expected roles and responsibilities often had detrimental influences on women's health. This type of information is critical for healthcare professionals in order to reach these individuals effectively. By taking into account women's relationships with family, as well as their influence on women's health, both physicians and educators can better serve the needs of this group and improve their health-seeking behaviors.

Sadler et al. (2001) specifically examined Asian Indian women and their knowledge and behaviors surrounding breast cancer. Surveying over 150 Asian Indian women, it was determined that although a significant number of these participants undergo an annual mammography, their self-breast exam rate is relatively low compared with other groups. Several cultural factors can indicate possible reasons for this low participation. First, Asian Indians have a high respect for authority and often defer judgment to the higher power. For this reason, Choudhry (1998) noted that these women believe that detection is their physician's responsibility and not their own. Additionally, Asian Indian culture considers touching oneself a taboo

(Choudhry et al., 1998), making self-breast exams problematic for these women. Finally, family is extremely important for this population. Ramakrishna and Weiss (1992) argued that Asian Indian women often place their families' concerns first. Consequently, they may feel guilty taking time to monitor their own health. These cultural issues can dramatically impact the health and well-being of these women, and Asian Indians in general.

Despite a number of research studies and their dramatic increase, Asian Pacific Islander Americans remain one of the least understood and most invisible and neglected minority groups in the United States, especially in the context of health status and health service utilization. Information on their healthcare needs, barriers they face in their access to health services, and their quality of life remains sparse. Although in some local areas they are organized to advocate for changes in healthcare delivery, their collective impact at the national level has not been reflective of their growing numbers or their special needs.

Asian Indians and Healthcare

The 2000 United States Census confirms earlier assertions that the Asian Indian group is one of the fastest growing ethnic communities during the last decade. A total of 1,678,765 Asian Indians called United States as their home at the time of 2000 census, making them the third largest Asian group after Chinese and Filipinos (U.S. Bureau of the Census, 2000). Most of the growth in population among Asian Indians is through immigration and less through natural increase. The Asian Indian immigration took on a fast phase after the 1965 U.S. immigration act abolished a national origins' quota system. However, the surge was limited to a 20,000 per country ceiling. The relaxation of immigration regulations attracted many adventurous and talented professionals from India for the first time. The percentage change in immigrants from India between 1965 and 1977 was about 3098.1 (Dinnerstein and Reimers, 1982). The 1990

comprehensive immigration legislation increased the total immigration to 700,000 during the fiscal years 1992 through 1994. Unlike earlier immigration regulations, this 1990 legislation created a separate category for family-sponsored, employment-based, and diversity of immigrants. For example, there were 30,667 persons from India that were admitted under new regulations in 1990, compared to 45,064 in 1991, 34,629 in 1992, and 40,021 in 1993 (INS, 1994). It is expected that the family re-unification and favorable global economy would likely promote conditions conducive to higher immigration levels from India in the future. By examining more current data, it becomes evident that this assertion is true. In 2004, 70,151 Asian Indians immigrated to the United States, and in 2005, this number rose to 84,681 (U.S. Department of Homeland Security, 2007). This steady growth underscores the need to further examine this population to better understand their needs.

While Asian Indians have been present in the United States for hundreds of years, it was not until the 1980s that the United States began to collect and record information separately for various ethnic minority groups. Several studies have been conducted based on the 1980 census data such as a census monograph on Asian Indian demographics, occupational structure, and family structure (Xenos, Barringer, & Levin, 1989). However, the term Asian Indian has had a somewhat more confusing history than other ethnic terminology to describe ethnic groups such as Koreans, Chinese, etc., for the general population. This uncertainty arises from the fact that Native Americans are often referred to as Indians in the United States. Additionally, varied terminology has been adopted by mass media in referring to Asian Indian groups such as East Indian community, Asian Indians, Asian Americans, immigrants from India, etc., and there seems to be no consensus on standard terminology universally.

Asian Indians, just like other minorities, representing a group with a tremendous amount of diversity, from food and customs to socioeconomic status. However, this population has an added complexity in that they also do not share the same language. While the national language is Hindi, only about 40% of Asian Indians are fluent and use this language on a daily basis (Shapiro, 2001). Instead, individuals use a dialect that is unique to the region of India in which they live. This variance in communication creates a type of "segregation" within the community, as people tend to socialize and interact with those individuals who share a common language.

Though this diversity does make it increasingly difficult to examine this population, there are still similarities that exist across these subgroups. In regards to healthcare, many Asian Indians, especially elders, believe in the traditional system of medicine called Ayurvedic medicine as the means of preventing and curing illness. Ayurveda is an intricate system of healing that originated in India, thousands of years ago. Ayurveda is made up of two Sanskrit words, 'Ayu' meaning life and 'veda' meaning the knowledge of (Channa, 2004). Ayurveda is not merely a medical system dealing with physical disorders. It is a science that relates to the complete human being (body, mind, senses and soul). It explains how balance can be attained physically, mentally and spiritually. According to it, each individual is made up of three doshas (vata, pitta or kapha). Each Dosha represents certain bodily activity. The ratio of the doshas varies in each individual. When any of the doshas becomes accumulated, Ayurveda will suggest specific lifestyle and nutritional guidelines to assist the individual in reducing the dosha that has become excessive. They may also suggest herbal supplements to hasten the healing process.

There are also aspects of the Hindu religion that commonly affect healthcare decisions. Hinduism is a social system as well as a religion; therefore customs and practices are closely interwoven. "Karma" is a law of behavior and consequences in which actions of past life

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affects the circumstances in which one is born and lives in this life (Panganamala & Plummer, 1998). Despite complete understanding of biological causes of illness, it is often believed that the illness is caused by Karma.

Additionally, the Hindu philosophy offers differing views on death and dying, and thus these immigrants often do not seek the same end-of-life care as others living in the United States (Desphande, Reid, & Rao, 2005). Furthermore, a majority of Asian Indians are not aware of the services that are provided in the United States, such as hospice (Doorenbos, 2005). Working to understand their cultural beliefs, healthcare professionals will be able to more effectively meet the needs of this fast growing elderly population.

Chapter Summary

This chapter broadly reviews the literature in four areas of research in order to set up the theoretical framework for the current study. First, the relationship between culture and learning, and adult education specifically, are overviewed. Second, definitions of cultural values, research on national cultures, and Asian Indian cultural values are addressed. Third, definitions of informal learning, along with its key characteristics and features, are provided. Finally, Asian Pacific Islander American healthcare is examined, leading into a discussion of Asian Indian healthcare specifically.

Culture and learning are interwoven and inseparable (McLoughlin, 1999). In the field of adult education, the awareness of cultural issues manifested itself in critiques of traditional learning theories, such as andragogy and self-directed learning. Caffarella and Merriam (2000) criticized these theories as neglecting the context of learning and the background of learners. Amstutz (1999) and Lee (2003) highlighted that these theories are based on the mainstream culture of the Western, White, and male populations. Pratt (1991) analyzed the cultural

foundations of andragogy as having been rooted in the soil of Jeffersonian democracy. This theoretical analysis was supported by other empirical studies (Alfred, 2003; Merriam & Muhammad, 1999; Pratt, 1990, 1991, 1998), which further reveals how cultural factors impact the learning process of learners from different societies.

Culture can be defined as the learned and shared knowledge, belief, values and habits (Krochber & Kluckhonn, 1952; Useem & Useem, 1963) which distinguish one group of people from another (Hofstege, 1980). Values represent the core of a cultural system and serve as a standard for people to make judgments in their lives. Studies indicate that Asian Indians value collectivism, hierarchy, family, and community (Merriam & Mohamad, 2000; Pai & Adler, 2001; Roland, 1998). These beliefs shape these individuals' learning process.

Informal learning takes place outside of formal institutions and can occur in many contexts, such as on the job, within family relationships, or in leisure pursuits. Although this form of learning is often considered residual, researchers still argue that much of adults' learning takes place in this manner (Cairns, 2000) and happens continuously (English, 2000). Networking is a type of informal learning which is readily evident in the Asian Indian community. Additionally, English (2000) illustrated the spiritual component of this particular learning style by highlighting the importance of utilizing pre-existing relationships. By consulting one another, informal learning allows for not only individual growth, but also community growth, a key value among Asian Indians.

Just as cultural values shape the learning process, such beliefs also play a role in healthcare. Asian Pacific Islander Americans (APIAs) represent the fastest growing ethnic group in the United States, and Asian Indians rank third among this extremely diverse minority population. Although research has been done on APIAs in general, this group is composed of

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over thirty-two different national ethnicities (Austin & Prendergast, 1994). For this reason, it is imperative that studies focus on specific APIA subgroups rather than generalizing findings to the group as a whole. For example, studies show that there is still a strong belief in traditional medicine such as Ayurveda among Asian Indians (Channa, 2004). Additionally, the teachings of Hinduism play a role in the way these individuals view sickness and well-being (Panganamala & Plummer, 1998). Similarly, these beliefs also impact one's perception of death and end-of-life care (Desphande, Reid, & Rao, 2005; Doorenbos, 2005).

Although there have been several studies specifically with Asian Indians, much is still unknown about these immigrants. Research indicates that cultural values impact learning as well as health, but little is understood about the intersection of these two concepts. As the elderly increase among this population and their need for health services magnifies, it will become critical to understand how these individuals' cultural values shape their learning and other health-related behaviors.

CHAPTER 3

METHODOLOGY

The purpose of this study was to explore how Asian Indian cultural values shape the health-related behaviors of older Asian Indian immigrants living in the United States. The research questions that guided this study were: (a) How do older Asian Indian immigrants learn about health-related issues? (b) In what ways does culture and heritage affect older Asian Indian immigrants' health behaviors? and (c) How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches? This chapter describes the methodology that will be used to examine these questions and is divided into the following sections: the design of the study, sample selection, data collection, data analysis, validity and reliability, assumptions and limitations, and a chapter summary.

Design of the Study

Given the limited information on the target population, and more specifically the issue under investigation, a qualitative approach was best suited to further understand the role of cultural values and its impact on the health-related behaviors of older Asian Indian immigrants. According to Merriam (1998), qualitative research is interested "in process rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation" (p. 19). This description highlights the goal of this particular research project. Rather than looking for correlations or significance between variables, this study focuses on the learning and negotiation processes Asian Indian immigrants use when confronted with health issues.

In contrast to a quantitative approach which assumes one objective reality that is measurable (Crotty, 1998), qualitative research recognizes that meaning is socially constructed by individuals in interaction with their world. Reality is not a fixed, single, or quantifiable phenomenon as indicated by a positivistic perspective. Rather, there are multiple constructions and interpretations that are fluid and constantly changing with time (Merriam & Associates, 2002). Thus, qualitative researchers are interested in understanding these interpretations at a specific point in time and in a particular context. Learning about such experiences and the meaning that they possess for individuals is deemed an interpretive qualitative approach.

This form of inquiry attempts to achieve an understanding of how people make sense out of their lives (Merriam & Simpson, 2000). In order to explain this process, researchers employ inductive techniques, building toward theory from observations and intuitive understanding. Data is gathered in order to build concepts and formulate hypothesis and theories, rather than deductively developing postulates to be tested (Merriam, 1998). The collection of this type of information occurs in the field, whether it is a specific site, group of people, or institution, with the researcher immersing himself or herself within the context, thus becoming the primary instrument for data collection. With this approach, findings typically result in the identification of themes, patterns, typologies, and even theories, which help to illuminate an issue that has not previously been studied extensively.

A qualitative design best suited my study because it allowed me to conduct an in-depth exploration of a complicated phenomenon that has received little attention. This approach enabled me to go beyond a superficial comparison of the differences between Western and Eastern cultural values. A qualitative inquiry provided me with an inductive research strategy and enough flexibility to analyze the themes, concepts, topics, and hypotheses for understanding

these immigrants' experiences. As the primary data collection instrument, I reported pertinent information about the research context and participants, collected the richest data that relates to the topic, and maintained interactions with both the data and the participants throughout the entire research process.

<center>Sample Selection</center>

Yet another difference between quantitative and qualitative research lies in the sampling approaches utilized within each method. While quantitative research depends on random sampling in order to generalize the results to the larger population and avoid bias, qualitative research focuses in-depth on relatively small samples that are chosen purposefully. Patton (2002) notes, "The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth" (p. 230), which have the potential to yield insights and in-depth understanding rather than empirical generalizations. This form of participant selection focuses on selecting information-rich cases whose study will clarify the questions under study.

Patton (2002) describes a number of strategies for this type of sample selection, and for this study, the snowball sampling approach was the most appropriate. This particular type of sampling involves locating information-rich cases by asking key informants within the community for recommendations. In addition to choosing the appropriate sampling strategy, it was equally important to identify the specific criteria necessary for locating information-rich cases. Based on the purpose of this research, participants had to meet the following criteria:

1. I am interested in understanding how culture shapes the health behaviors of older Asian Indian immigrants. For this reason, it was critical that my participants meet a certain age requirement in order to qualify as older adults. I interviewed individuals who are 60 years of age or older. I believe that this age range provided me the flexibility to obtain an

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appropriate number of participants while still focusing on older adults within the Asian Indian community. I am examining older adult immigrants because, due to their age, these individuals are more likely to need and utilize healthcare services than younger Asian Indian immigrants.

2. Participants should not have been living in the United States for an extended period of time. Individuals who came to the U.S. at the age of 40 or later would have begun the acculturation process, but not have become completely Westernized. Furthermore, they will be more in tune with their heritage and cultural values. There is also a higher possibility that the behaviors and norms that were acceptable and standard in India are still prominent and affect these individuals' decision making process here in the United States. This factor is critical in understanding how culture shapes the health behaviors of these immigrants, as well as how they navigate the healthcare process. After 3 months of recruiting and finding only one appropriate participant, it became necessary to reevaluate my selection criteria. Upon further consideration, this was the only qualification that could be removed and not dramatically impact the study. So, I decided to forgo this stipulation.

3. Participants, or their immediate family (defined as spouse, children, brothers, and/or sisters) should not be healthcare professionals, such as nurses, physician assistants, or physicians. Although these practitioners will have insight into the research topic, it is believed that these individuals will be too entrenched in Western medical practices. Even if they have been trained in India, where they are more likely to have been exposed to alternative methods of treatment, the fact that these people are practicing in the United States indicates, in some form or fashion, that they value western remedies over its

eastern counterparts. It can be argued that this is a generalization, but a test interview

with an Asian Indian physician indicates this to be true. For this reason, it is prudent to

target individuals who are not trained in healthcare practices.

    4. The sample group should represent a range of genders, ages, and regions of India.

Using these criteria, I began my search for qualified participants by contacting Asian Indian

organizations and temples, via telephone. I described the purpose of my study, the type of

people I was seeking, and asked if they knew any suitable participants who would be interested

in speaking with me. I also sent an email to friends and family (Appendix A) detailing my

research and requested them to notify me of any individuals who would be willing to meet with

me.

I located 11 participants that met my selection criteria. All individuals interviewed for

this study were adults upon coming to the U.S.   All participants were informed of their right to

withdraw from the study at any time and confidentiality was assured along with a description of

how pseudonyms were to be used to protect their identity. Since in qualitative research there are

no specific requirements for sample size, sampling to the point of redundancy is an ideal (Patton,

2002). Lincoln and Guba (1985) explain: "In purposeful sampling the size of the sample is

determined by informational consideration. If the purpose is to maximize information, the

sampling is terminated when no new information is forthcoming from new sampled units; thus

redundancy is the primacy criterion" (p. 202). By the eleventh interview I was reconfirming

what other participants had said, no longer finding new information, and had generated sufficient

data for my research.

Data Collection Methods

Of the various qualitative data collection techniques, semi-structured interviews was most suitable for this research. I used this approach as the major data-gathering technique for my study. The interview was recently defined by DeMarrais (2004) as "a process in which a researcher and participants engage in conversation focused on questions related to a research study. These questions usually ask participants for their thoughts, opinions, perspectives or descriptions of specific experiences" (p. 54). Merriam (2002) and other qualitative methodologists view an interview as a conversation between two people that is focused on the research topic, or as Lofland and Lofland (1995) described it, "a guided conversation" (p. 18). In contrast, Misher (1986) argues that "even questions that are apparently simple in both structure and topic leave much room for alternative interpretations by both interviewer and respondent" (p. 45). Rather than a simple exchange, he believes the interview to be a type of discourse where both the researcher and participants work together to create meaning within a particular type of social relationship.

However one views the concept of interviewing, this approach was well-suited for my study. My research questions focused on the learning experiences of older Asian Indian immigrants, as well as determining how they negotiate their social and cultural identities within a health context. These types of experiences are difficult to capture through surveys, and are better understood through direct conversations with participants. As Patton (2002) observes,

> We interview people to find out from them those things we cannot directly observe…We cannot observe feelings, thoughts, and intentions. We cannot observe behaviors that took place at some previous point of time…We can not observe how people have organized the world and the meanings they attached to what goes on in the world. We have to ask

people questions about those things. The purpose of interviewing, then, is to allow us to

enter into the other person's perspective. (p. 341)

There are many ways to conduct an interview, ranging from a strict, structured interview to an

entirely open-ended format. A semi-structured approach allows the researcher the opportunity to

"explore a topic more openly and to allow interviewees to express their opinions and ideas in

their own words" (Esterberg, 2002, p. 87). Through this method, though the researcher is guiding

the discussion, the participants are still able to steer the conversation by communicating their

views on a particular issue. I created an interview guide (Appendix B) that consisted of open-

ended questions related to the issue of culture and healthcare. This guide provided topics or

subject areas "within which the interviewer is free to explore, probe, and ask questions that will

elucidate and illuminate that particular subject" (Patton, 2002, p. 343). The semi-structured

interview allowed me to remain flexible and open to the different experiences of my participants,

modifying the questions to make them personal and relevant for each participant. By

incorporating this method I was able to focus the interview to encourage efficiency and allow for

the greatest opportunity for varied response from participants. Specifically, I considered

issues of time, participant apprehension, uncertainty, or lack of understanding

about the questions. The interview format consisted of questions intended to encourage the

participants to explore their experiences with being ill in the United States. Interviews ranged

from one to two hours in length, with a large portion of time dedicated to asking

participants to describe their experience(s) with being sick, and how they made decisions

regarding treatment (see Appendix B for interview guide).

All eleven interviews were conducted in person at a location of the participant's choice.

The interviews were tape-recorded and then transcribed verbatim to typed format for analysis. In

two cases, follow-up phone calls were necessary to clarify statements and misunderstandings. This not only served to clarify or strengthen emerging themes and ideas in the data, it also gave me insight into how to modify questions for future interviews. Field notes were made following the interview to highlight my own feelings, reflections, and observation (Bogdan & Biklen, 2003). An example of such notes included short descriptions of my impressions, such as: "tall and physically fit" or "shy but jovial."

At each interview, I also invited the participant to share any documents that related to their experiences with health-related behaviors. This could have included diaries, appointment calendars, pamphlets, brochures, and any other materials that represent the individual's learning and negotiation of health issues. However, none of the participants had any such information to share.

Data Analysis

Data analysis refers to making meaning of what people have told of their experiences. According to Merriam (1998), data analysis is a complex process that "involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, between description and interpretation" (p. 178). This process occurs throughout the course of the research. Although there are a number of strategies for analyzing qualitative data, the constant comparative method developed by Glaser and Strauss (1967) served as the primary analysis method in this research study. Maykut and Morehouse (1994) note that the four main steps of this form of analysis are: 1) inductive category coding and simultaneous comparing of units of meaning across categories, 2) refinement of categories, 3) exploration of relationships and patterns across categories, and 4) integration of data yielding an understanding of the people and setting being studied.

This analysis began simultaneously with the data collection process. Analysis started after the first interview, and each following interview was informed by the previous conversation. Each transcript was scrutinized in turn line by line, sorting out the units of meaning deemed relevant to the research questions, and then coded by topic, participant's pseudonym, and line number. As I read each interview, I identified significant words and phrases in the participant's own words. For example, when discussing illness, the first interviewee repeatedly used phrases such as "family involvement" and "valuing traditional medicine." Comparing subsequent transcripts I looked to see if the same or similar phrases occurred, while continuing to look for new terms. "Skepticism" and "personal relationships" appeared in later interviews, and therefore I returned to early interviews to see if I had overlooked those concepts, or similar ones, in the preliminary stages of data analysis. Once all the data had been reviewed, findings were aligned with possible properties of each category, and then the categories were reduced into a smaller number of conceptual themes and recorded.

One example of this analysis was when I examined my first research question: How do older Asian Indian immigrants learn about health-related issues? Besides formal classes suggested by a healthcare professional, participants described activities such as conversing with friends and family, reading magazines, browsing the Internet, and even watching TV. These examples were compiled and based on the forms of learning discussed I assigned the category of informal learning.

<div align="center">Validity and Reliability</div>

Reliability and validity are indicators that are used to determine the trustworthiness of research. Reliability refers to the degree to which the results are consistent with the data collected (Bogdan & Biklen, 2003) or the extent to which a researcher's findings can be

replicated. However, since human behavior is not static and there are many interpretations of a particular phenomenon, it is almost impossible to repeat a study in order to establish reliability in the traditional sense. Lincoln and Guba (1985) suggest thinking about the dependability or consistency of the results obtained from the data rather than demanding identical outcomes from other researchers. Similarly, Merriam (1998) recommends using techniques such as specifying the investigator's position, triangulating data collection, and using an audit trail to ensure the dependability of the results.

Validity is composed of both external and internal validity. Internal validity refers to whether research findings are congruent with reality (Merriam & Simpson, 2000). However, within qualitative research, reality is multidimensional and ever-changing. For this reason, the researcher needs to demonstrate that he or she accurately and adequately represents informants' constructions of their views and experiences (Merriam & Associates, 2002). Various strategies have been developed to improve internal validity, including triangulation, member checks, peer examinations, and clarifying the researcher's assumptions (Lincoln & Guba, 1985; Merriam, 2002). The use of triangulation can strengthen a study by combining methods, using several kinds of methods or data, or including both quantitative and qualitative approaches (Patton, 2002).

External validity or generalizability refers to the extent that the findings of one study can be applied to other situations. Since qualitative studies use purposely small selected samples, it is impossible to generalize these results to the larger population. Instead, Merriam (1998) suggests using reader or user generalizability, in which "readers themselves determine the context to which findings from a study can be applied to their context" (p. 29). For this reason, external validity focuses on the transferability of the findings to other studies. The reader or user

of the information determines the generalizability of the information presented. I do not

speculate how findings apply to others, but instead allow the reader to determine the applicability

of the information. To accomplish this, I used as much thick description as possible, rich with

detail, resulting in an audit trail that provides readers with a way to understand how I

reached my findings. By doing so, I hope readers will be able to determine for

themselves if the information in the study is relevant in their own lives.

I implemented a number of strategies into my research project to help ensure both

reliability and validity. I utilized member-checks to enhance my findings. Member checking

involved taking emerging or tentative findings back to a number of participants for their

assessment. This was accomplished through e-mails to participants. I sent emerging findings to

all participants and received replies from three. Reactions were positive and responses indicated

surprise, with comments like this one in reply to the importance of context, "Wow I didn't think

of it that way, but you're right!" I also used peer examination, utilizing colleagues in a

dissertation-writing group to comment on the plausibility of the findings.

Reliability in quantitative work makes certain that study findings can be replicated, but in

qualitative inquiry, reality is constantly in a state of change, making it difficult to ensure

reliability. Merriam and Simpson (2000) that reliability asks if the "results are consistent with the

data collected" (p. 102). Reliability provides consistency and dependability to a study, and in this

study, three strategies were employed: peer review, an audit trail, and a statement of my

subjectivity. The first strategy, peer review has already been described. An audit trail will give

readers of this study a description of how I arrived at the findings. This means that I provided

detailed documentation of the data collection process, reporting of my decision making

processes, and an explanation of the steps used in the data analysis. Finally, reliability will be

strengthened through an explanation of my subjectivities, including my assumptions and biases about the research. This informed readers about how I approached the undertaking of this study.

<div align="center">Assumptions and Biases</div>

My own opinions and biases affect many, if not all, components of the research process. It is critical to "develop an understanding of how our positions shape the research topics we choose and the methods we use to study the social world" (Esterberg, 2002, p. 12). Thus, I can work to minimize this occurrence by recognizing my limitations up front.

First, it is important to have a clear understanding of what one considers accurate and valid data. I firmly believe that meaning is constructed from experiences. This perspective affects my entire research process, from the type of questions that I explore to the methodology that I choose to implement, and thus it is imperative that I am cognizant of these implications, as they will not only shape the research design, but also the information that I will find. Although I believe that analyzing the experiences of individuals yields unique and valuable data, I am also aware that this approach has its limitations and recognize the need for alternate viewpoints.

Second, it is critical to note my connection to the population that I am studying. I too am Indian and thus have a vested interest recording the experiences of this group and increasing their representation in the research literature. However, although I am Indian, I was born and raised in the United States, and this upbringing affords me some differing viewpoints from first-generation Indians. Though this allows me the opportunity to be both an insider as well as an outsider, it also produces a slight challenge in gaining the trust and confidence of the participants. With this study, the fact that I was an outsider, being born and raised in the United States, altered the way in which my participants provided certain information. During the interviews, it was apparent that individuals felt they needed to elaborate or clarify certain issues

because I have not lived in India. There was an underlying assumption, sometimes correct and sometimes incorrect, that I was not aware of specific customs, and/or rituals. This belief prompted participants to provide additional details and explanations that they would not have offered to other individuals who immigrated to this country from India.

Class and gender also impacted this study, both in sample selection and in interactions between myself and the participants. Since I used snowball sampling to locate participants, my own class shaped the demographics of the individuals that participated in my study. My family, along with their circle of friends, are mostly upper middle-class and highly educated. Because I utilized this network to recruit individuals for my study, all of my participants were also well educated. My status affected the people that I reached during recruitment and thus impacted the make-up of my sample. Additionally, my gender influenced how participants, especially men, responded and interacted with me. I was often viewed as a daughter, and this helped to build confidence and improve rapport between myself and the participant. Individuals often shared stories about their own daughter(s) and as they helped me with my research they were reminded of how their own family and friends aided their children in times of need.

Finally, it is essential to highlight my own biases about medical practices. Growing up in a family of doctors, I have always been surrounded by Westernized medicine and its practices. Although I have been exposed to some Eastern approaches on my trips to India, I have never been a strong follower of these types of alternate medicine. Additionally, my upbringing has always strongly emphasized preventive medicine, a concept still quite foreign in India and for many first-generation Indians living in the United States. With this research it is vital that I suspend these beliefs to more clearly understand the role that culture plays in the health behaviors of my participants.

Chapter Summary

This chapter presented the methodological process and related techniques that will be used to explore how cultural values shape the health behaviors of older Asian Indian immigrants. The research design, sample selection, data collection, and data analysis of the research process were described. A qualitative research design was used and in-depth interviews were the primary method of data collection. Eleven Asian Indian immigrants who are 60 years of age or older and are not affiliated with a health profession, were purposefully sampled as research participants. The constant comparative method was used to analyze the data in order to determine common categories, themes, and patterns across the research sample. In order to enhance reliability and validity, member checks, peer review, and an audit trail will be used in order to increase the trustworthiness of this study.

CHAPTER 4

FINDINGS

The focus of this qualitative study was to understand how cultural values shape the way older Asian Indian immigrants in the United States learn about health-related behaviors. Three questions guided this research: 1) How do older Asian Indian immigrants learn about health-related issues? 2) In what ways does culture and heritage affect this population's health behaviors? and 3) How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches?

This chapter begins with an overview of the eleven participants who comprised the sample. Second, the findings will be discussed in terms of each research question, with supporting data from the interviews provided as evidence.

Participants

As stated in Chapter Three, individuals for this study were chosen based on snowball sampling. Furthermore, participation was based on the following criteria: (1) 60 years of age or older and (2) they or their immediate family (spouse, children, or siblings) must not be a nurse or physician. Originally I had hoped to find individuals that had come to the U.S. at the age of 40 or older. But after recruiting for three months and finding only one person who met all three criteria, I chose to omit this qualification, as the other two conditions were non-negotiable. As illustrated in Table 1, the sample consisted of 8 males and 3 females, with ages ranging from 60 to 70 years old.

Table 1 - Participant Information

Name	Gender	Age	Years in US	Region of India	Health Status
Deepak	M	65	35	North	Healthy
Raj	M	64	37	South	Cancer; in remission
Babu	M	70	39	South	Healthy
Suresh	M	65	25	South	Diabetes
Hanuman	M	65	36	North	Diabetes
Leela	F	60	41	South	Healthy
Balram	M	64	32	North	Healthy
Anita	F	67	38	South	Healthy
Bansi	M	60	33	South	Diabetes
Jai	M	70	41	South	Healthy
Nirali	F	67	2	South	Healthy

All participants had at least a Bachelor's degree, with about half completing their education in India and the others coming to the United States for higher education. In addition, the participants represented various regions of India. Although these individuals have been in the United States for an extended period of time, all of them came to the U.S. during adulthood.

Deepak

Deepak is a 65 year old man who is from a large city in the northern part of India. He has been in the United States for 35 years and currently lives in the Southeast with his wife, where they own and run a small business. While he often mentions that he was not heavily exposed to English in India, his many years in the United States and serving customers has helped him to become more confident, comfortable, and fluent in the language. He has a son and a daughter who both live close by. We met at my home for the interview, which was conducted after we shared tea and a small snack. Deepak, a tall gentleman with a mustache and graying temples passionately shared his experiences with being ill, seeking healthcare in the United States, as well as the differences he sees between treatment in the U.S. and in India.

Raj

Raj is a 64 year old South Indian gentleman from a small village in Southern India. The pursuit of education brought him to the U.S., where he obtained his Masters degree from a university in Southwest. He has been residing in the United States for 37 years, living most of that time in the Southeast, where he works as an engineer for a large electrical company. He has a wife, who is also working, and two daughters. One daughter is pursuing a Masters degree while the other is living and working in a nearby state. Raj, a tall man with gray hair that is beginning to bald, invited me over to his home for the interview. Upon meeting it was evident that he was physically fit for his age and it would be difficult to know that he was in remission from cancer. Soft spoken and gentle, he shared with me his ordeal with this disease, along with the physical and emotional struggles that accompany treatment.

Babu

Babu came to the United States from a region in South India 39 years ago to pursue a post-doctoral fellowship in New England, which led to a research position with a large institute in Alabama, where he has spent most of his adult life. Now in retirement at the age of 70, he enjoys spending time with his wife, children, and grandchildren, as well as attending festivals and celebrations with other members of a local Asian Indian organization. Although he is 70 years of age, Babu's passion for fitness and good health is evident in not only his outward appearance, but in his mental and spiritual well-being as well. During these golden years he spoke with me about the strategies he uses to not only maintain physical fitness, but also about the importance of keeping his mind active.

Suresh

Suresh, a 65 a year old man, came to the United States from a city near Chennai 25 years ago to pursue his career. Now in retirement, he lives in the Southeast with his wife, son, daughter-in-law, and 2 grandchildren. A dark-skinned, plump, bald man with minimal gray hair at his temples and a welcoming smile, spoke with me about his trips to India and his continual struggle with diabetes. In his spare time he enjoys tinkering with electronic gadgets, perusing the Internet, and visits the local temple on a weekly basis with his family.

Hanuman

Hanuman and his wife run a wholesale retail business in a large metropolitan city in the Southeast. Although he obtained a law degree in India, he came to the United States seeking a better life for himself and his family. He has two daughters, one who has completed her doctorate, and another who is in graduate school. Now at the age of 65, after being in this country for 36 years and running a successful business, he is looking forward to retirement once his youngest daughter is finished with school. Even with his busy schedule, Hanuman invited

me to his business to show me around and speak with me. A jovial, mild mannered man, he eagerly shared with me his health concerns, his fear(s) of what the doctor would find, as well as his desire to live near his children after retirement.

Leela

Leela, a 60 year old lab technician, lives in the Southwest and has been in the United States since she was 19 years old, coming to this country immediately after she was married to follow her husband as he pursued his doctorate. An extremely outgoing and friendly woman, she invited me to her home for lunch. Although she has been living in the U.S. for many years, she still visits India frequently and her home is accented with art and décor that reflects Indian culture. When I arrived, she was wearing a black sari with pastel flowers, her mangalsutra (a necklace worn by married Indian women) and was in the middle of cooking a traditional South Indian meal.   She shared with me photos of her two daughters, one who recently got married in India, as well as her desire to retire in the next couple of years and go to India for an extended period to spend time with her family. She spoke passionately about her experiences with the doctors in the United States and in India, as well as her thoughts on homeopathic and ayurvedic medicine.

Balram

Balram came to the United States 32 years ago from India to have more career opportunities. Once an engineer at a large company in the Southeast, he is now retired and offers his consulting services to various clients. A deeply religious man, we met before his weekly commitment to the temple. He was wearing coral beads around his neck, which are used during ritual ceremonies and bhajans (sacred songs and chants sung during religious ceremonies). In his retirement he stays busy by having a leadership role at the temple, as well as actively

participating in other events within the Indian community, where he is able to enjoy the company of others.

Anita

38 years ago Anita came to the United States to follow her husband as he pursued higher education. Now at the age of 67, after working many years at a large research institute in the Southeast and raising 2 children, she is enjoying her retirement by finding time to relax. A friendly soft-spoken woman, she invited me over to her home one weekend for the interview. Her attire, sweatpants, a t-shirt, and her hair pinned back in a ponytail, was reminiscent of her carefree spirit. She spoke with me about her reluctance to take medication and how she still uses a number of homemade therapies that she learned from her family in India. Additionally, she emphasized her desire to stay active even during retirement, in order to keep her body, as well as her mind, healthy. In addition to exercising with her husband, she also enjoys cooking, gardening, and finally having the time for leisure reading.

Bansi

Bansi came to the United States over 30 years ago to obtain his doctorate. He now lives in the Southwest where he works as a researcher. A shy and soft spoken gentlemen, Bansi agreed to speak with me after another interview participant called and asked him to come over. A tall, slender man with gray hair and a thin gray mustache arrived about one hour later wearing khaki dress slacks, a button down shirt, and a vest. Although quiet, he greeted me with a smile and shared his experiences with the doctor, how he learned about diabetes, as well as how he manages this chronic illness.

Jai

When meeting Jai, it was evident that he was a proud and confident man. Tall and slender it was clear that he was physically active and it would be difficult to tell that he was 70 years old. When I first arrived at his home, Jai had just returned from his weekly visit to the temple. He was dressed in traditional Indian clothing, and had a bhindi on his forehead. Once he had changed clothing we had lunch before starting the interview. During the conversation it was clear that Jai was an intellectual man who prided himself on all of his accomplishments. He spoke of his commitment to exercising, mentioning that he and his dog walk several miles every day. He used to work at a large laboratory near his home, and he would bike to work each day. Now in retirement he enjoys the company of his friends as well as staying active in the temple, which helps to keep his mind, body, and spirit healthy.

Nirali

This 67 year old woman has been living in the Southwest for two years. She and her husband used to visit their two daughters frequently and when he passed away suddenly, her daughters encouraged her to apply for a green card so that she could stay with them on a more permanent basis. She now spends most of her time in the United States visiting both of her children, and returning to India for a couple of months each year. When I went to meet Nirali at her daughter's home, she was drinking a cup of tea and watching her two grandchildren. Her hair was black, with streaks of silver, and was held up in a bun. She was wearing a maroon Punjabi dress, had a gold chain around her neck, and a red bhindi on her forehead. She had an extremely pleasant demeanor and spoke English with great comfort and fluency. Speaking softly, she told me about how her husband passed away several years while they were visiting the U.S., her experience with paramedics, physicians, and the emergency room, as well as how she has coped with this great loss.

Findings

Findings are presented based on each of the three research questions guiding this study. As illustrated by Table 2, the participants utilized five main resources when learning about health issues: healthcare professionals, immediate family, media, the Internet, and the Indian community.

Table 2 - Overview of Findings

Research Question	Findings
1. How do older Asian Indian immigrants learn about health-related issues?	- Healthcare Professional - Immediate Family - Media - Internet - Indian Community
2. In what ways do culture and heritage affect older Asian Indian immigrants' health behaviors?	- Personal Relationship with Physician - High Level of Family Involvement - Valuing Alternative Medicine
3. How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches?	- Experiment with both systems - Adopt a skeptical approach to Western medicine

The second set of findings relate to the cultural values that shape these immigrants health-related behaviors. These include having a personal relationship with their physician, a high level of family involvement in the healthcare process, and the consideration of alternative medicines

when they are ill. The last set of findings explores how these participants mediate between Western and Eastern treatments of medicine. This process includes experimentation with both systems as well as adopting a skeptical approach to Western medicine.

<div align="center">Learning Resources for older Asian Indian immigrants</div>

When considering how older Asian Indian immigrants in the United States learn about health issues, the participants mentioned their healthcare professional as well as their immediate family. In addition to these individuals, they also make use of the media and the Internet. Finally, these immigrants also rely on the Indian community for information on health topics.

Healthcare Professional

All of the participants mentioned that they rely on their healthcare professional for accurate and pertinent health information, whether it is for a referral or knowledge about a treatment option that they are proposing. For example, when asked about how he checks and maintains his diabetes, Suresh shared, "The doctor gave me a little gadget which, you know, prick yourself and then read and give you all those things. In fact he pushed me into that habit." Similarly, Bansi notes, "she [the doctor] recommended some class that they gave me materials about diabetes and various medications." Both of these individuals not only looked to their physician for guidance, but also trusted that they were providing the best advice possible.

This trust in authority is one of the reasons that the healthcare professional is a main source of information for Asian Indians. These individuals believe that their doctor has their best interest in mind, which is echoed by Hanuman, "So if the doctor suggests something, I just follow him because he is my doctor and he is going to take care of me." This form of confidence can also be expressed as faith, which is how Balram described his experience, "So it was a mixture of hope, faith, and main thing is really faith was the main part you know…in doctor's

competence." All the participants not only believed in their physician's expertise but also relied on this knowledge during the decision making process. For example, Anita recalled how she changed her exercise habits after a consultation with her physician:

But, and I think this uh exercises in the weight bearing exercises in the gym is better because my doctor you know OBGYN had suggested that you know I start doing weight bearing exercises to improve the bone density and all that. He said, you know, the older you are the better it is to do weight bearing exercises. So that's how I started the exercises in the gym.

It also became clear that these participants not only viewed their healthcare professional as an expert, but also relied on them for reminders about exams and check ups. For instance, Suresh notes, "So I go to him every time and he tells me when I need to do what and all those things." Leela shared a similar experience: "my doctor she has a record she usually reminds me you know 'you're do for a physical why don't you make an appointment?' Often times she makes it herself on the computer," emphasizing that this type of service was critical in helping her maintain her health.

This reliance on the healthcare professional was even more evident in those individuals who were faced with a serious illness. For instance, when Raj was diagnosed with cancer, his doctor was his primary source of information, especially regarding his options:

Once it [the test] came positive then he gave me a book to read with all the options. And I talked to my doctor basically that's what you need. Plus, he gave me couple of people patients' name, addresses, and their telephone numbers so I could invite them for lunch then sit down and go through their experience after and uh so I had lot of uh information.

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This example illustrates how Raj's physician not only provided medical guidance, but also pushed him to find social support not only from family, but also from others who have had similar experiences. Balram also mentioned that his belief in his doctors' abilities, as well their knowledge about specific procedures helped to ease his discomfort about undergoing surgery:

> And then I had Indian doctors that uh, they were not experts in that area, but they are general doctor they generally know what do they do in a back surgery herniated disk, why it happens and what not, the statistics about the surgery, the success rate, what can go wrong and so on.

These physicians were able to provide Balram with information and guidance that increased his confidence in their suggestions for treatment.

Although these participants regard their healthcare professional as an expert, this did not always signify blind obedience. A couple of participants mentioned that there were times when they questioned their doctor's advice and did not follow through for various reasons. Hanuman shared one such story: "The doctor recommended that I should go and take a stress test, which I have been avoiding. He has been telling me for the last five years probably, but I have not gone for a stress test." While he has confidence in his physician, Hanuman is reluctant to have the procedure because he is afraid of what the test will uncover. "I am avoiding because I know if I go I will have some blockage and doctors will be 'Oh, we need surgery right away' and I am trying to avoid it." Fear of further testing, or even surgery, has caused Hanuman to disregard his doctor's request.

In a similar fashion, Raj chose an alternate path than the one recommended by his physician when he was being treated for cancer. "And as matter of fact, he [Raj's doctor] recommended me to go with laparoscopic surgery" he shared, "but at that time I did not feel they

had enough data." So, even though his healthcare professional suggested one form of treatment, Raj's own knowledge and research on the topic made him select an alternate option. Both of these examples illustrate that while these participants trust their physician, this faith does not always transform into adherence and/or compliance.

Immediate Family

The second resource that these participants utilized for health information was their immediate family, leaning on their spouse, children, and siblings when in need. First and foremost, these individuals depend on their family when seeking physician referrals. For example, Deepak shares,

> Oh, in India we didn't know who to go to, but she [his wife] went there and her brother knows lot of people. So one of his friends, a business man, and he wrote him [and] said take care of my sister. So he knew a doctor.

Even here in the United States, Asian Indians rely on their family for information about physicians. Suresh shared a story of a time when he was not receiving proper treatment and his daughter stepped in: "After that, I think couple of days later I was not feeling better, I was not getting the right treatment so then my daughter suggested this other doctor that was in uh the Alcoa area."

Being new to the United States, it was evident that Nirali relied more heavily on her family than the other participants for information and guidance. For instance, she relied completely on her daughter to find a physician when she was having a medical problem. She states, "I don't know how she found out, she found out through friends so through them she found out and then so we have taken appointment and then we went." She also mentioned that she often turned to her family for information while her husband was suffering with Parkinson's

disease. She remarked that after returning from the doctor's office, "I used to pester my sister and my brother to tell more" and "I used to ask my nephew, I used to ask him to get some books" to help her better understand the illness that was affecting her husband.

Participants also revealed that spouses were not only a source of information, but also provided encouragement to practice good health habits. This was especially true for the women in this study. For example, Anita mentioned that in addition to teaching her specific exercises, her husband "is very particular about exercise so that is how I started doing exercise every day. He is very knowledgeable in all these exercises. So he actually introduced me to all that." Similarly, Leela notes, "My husband pushes me to it…he says I'll go walking with you, he's an exercise fanatic he does not even miss a day of exercise." Nirali also mentioned that she and her husband would "go walking together" and encouraged each other to stay active. It was only after he passed away that she turned to her children for assistance. These women viewed their spouse not only as a partner, but also relied on them for knowledge as well as support.

In contrast, the male participants depended increasingly on their children and/or siblings when confronted with a health issue. For instance, Deepak notes that after experiencing heart problems, his daughter taught him to be more careful about the food he ate: "I never knew those labels, you know, Avani [his daughter] told me you have to see saturated fat, this and that. And now I'm always reading labels." Likewise, Suresh relied on his children when he was not feeling well. "My son helped me to go to the hospital," he explained, "he was with me going to the doctor's office and at the doctor's office the decision was made to get into the hospital."

Others looked to their siblings for guidance and assistance. For example, Hanuman, who struggles with diabetes, comments that his sister is continually sharing information with him:

My sister who lives in New Haven she is very much involved in vitamins, so she always, if I call her she gives me two hour lectures on the phone that I should do this, and not do this, and I should take this vitamin every day, and all that.

Bansi is also afflicted with diabetes and suffered for many years before being properly diagnosed. "My brother told me I should have him to recommend me to a diabetic specialist," he shared, emphasizing that his brother's comments encouraged him to seek out another healthcare professional to properly treat his condition. For the male participants, both siblings as well as children were integral sources of knowledge.

Although family involvement was often regarded in a positive light, some participants also indicated guidance from spouses, siblings, and/or other family members can be difficult at times. Raj spoke of an instance when his grandmother was determined to treat his illness in a particular way. "All the treatment I had was some herbs and a strict diet." While he understands that this form of treatment is preferred among some Indians, he noted the difficulty he had in relying solely on this type of treatment. ""I was very lucky I recovered," he shared, "it took me about two months to recover."

Leela also expressed a negative aspect of family involvement. While she appreciates their concern and support, she stated, "Everyone has their own perspective, they want to help and they each have their own viewpoint. Sometimes it can be overwhelming." With so many people involved, the treatment process can become a burden. For example, Leela noted that her family is constantly questioning her about her medication: "They keep uh sending me emails [asking] are you taking your medication, you know? And all of my sisters, when I call [they say] 'are you taking the medication? Don't neglect to take the medication.'" While these reminders can be useful, at times Leela finds them slightly distracting and intrusive.

Media

The media, such as television, radio, and popular magazines, was also used by these individuals to learn about varying health topics. For instance, when asked how he learned about free local prostate screenings, Deepak shared, "They were advertising on the radio and local newspaper and so I said let's go." Similarly, Balram shared this story to illustrate why he began yearly exams:

But after I saw this one [a magazine article] I said boy, then reading lot of articles it says after certain years of age you should be going for this one regularly, after this age you should be doing this one and it was common knowledge after 50 years you should be more uh paying attention to what you do, your exercising, your uh health.

Numerous participants mentioned that they utilize the media to stay updated on current health issues. Babu notes, "Well I read uh you know health uh magazines and that kind of thing. Popular articles, and newspaper."

Information seen through the media also drives these individuals to learn more about various health topics. For example, Deepak shares this story:

But then I found out, uh, I was listening to news and one of these guys was talking about Bush and he [asked] how good health is Bush in? And he said Bush is in good health, every morning he exercises and he brings his heartbeat up to so much and everything.

After hearing this clip, Deepak began to wonder about the connection between exercise and one's heartbeat and he sought out additional information:

And I was wondering there is something about this, and I was reading in there and I found out that just half an hour exercise, I mean you walk fine, exercise fine, but you

have to bring your heartbeat up to certain level. And then I talked to my friend, how you

figure out and then he told me 220 minus your age, that's your heartbeat.

This story illustrates how the media was an instigator for Deepak to learn more about a specific

issue that was important to his health and well-being. Bansi also shared an instance where the

media sparked his curiosity. When discussing how he learns about different exercises, Bansi

noted, "I saw it on TV, like a PBS show had some on yoga and I saw them and tried it while

watching the TV and I got a book from the library." The media was a vehicle for learning by

introducing new concepts, thus encouraging these participants to seek out additional information.

Magazines and other reading material were a particularly important resource for the

women in this study. Articles, whether in popular magazines or research journals, helped these

women to learn more about a particular issue, as well as introduce them to new issues. For

example, when asked how she learns about health topics Anita shared, "I uh I read these uh you

know health magazines you know every month they send some articles about health." Both

Nirali and Leela mentioned that they use reading material to help them better understand medical

conditions. When Leela was diagnosed with a problem, she went to the library and "read

everything I could find in books and magazines" to better comprehend her condition, its

symptoms, as well as available treatments. In a similar fashion, Nirali noted "I'm interested to,

even when my daughters uh get some problem also, I used to read [about] those things." From

their stories it was evident that all of these women preferred written material over other forms of

media when seeking health information.

Internet

All of the men in this study used the Internet in some way to learn about varying health issues. Some mentioned its use in passing, simply noting that it was yet another information source. For instance, Babu mentioned:

> You can go to Internet and you can find out lot of things. On a regular basis I go on the Internet and read what is happening you know, especially if it is related to cholesterol and you know that kind of thing.

However, others utilized this technology for specific purposes. Jai made use of the World Wide Web to learn more about a recommended physician when he was in need of surgery. He notes, "When we found out this guy's name, and we went to the internet and found out his qualifications and what in all on him."

In addition to searching for doctors, these individuals also used the Internet to learn about particular diseases. For example, Raj revealed how the Internet helped him while he was struggling with cancer:

> I went to the Internet. There are so many, with the Internet there is so much information. You can go to the American Cancer Society and go to the websites and read the experiences of lot of other people. So you can read lot of information.

For Deepak the information on the Internet encouraged him to seek medical attention for a problem that he had been ignoring:

> I go and ask for prostate cancer symptoms and everything and I read that and this is me, this is me, this is me, I knew that. But yeah I started because you go on computer and check it online. So everyday I learn.

Suresh shared that he uses the Internet to help him learn how to maintain his diabetes. He notes, "There is so many medical websites that talks about uh diabetic foundations, there are so many

websites I don't remember specific particular name." Overall, the Internet serves as a major learning tool for these immigrants. Balram and Bansi both expressed that the Internet was a resource that they utilized to learn more about issues of interest and/or personal consequence. "If there is a need, if I say I want to know about this one because it is close to me or whatever, then I will try [going on the Internet]," shared Balram, noting that while he does not surf the Internet regularly, it still serves as a source of information in times of need. Bansi sums this up by stating, "I used the internet to learn about other things like, even though I don't have these problems, heart attack, heart disease, I just want to learn about them, so I went to the Internet and read about it."

The women in this study were less likely to utilize the Internet as a source of information. And even when they did use this technology, it was with someone else, generally their spouse. For instance, Anita shared "We [my husband and I] look up on the Internet um just you know stay up to date on the issues of older people." Likewise, Leela expressed that she and her husband used the Internet to find out about physicians specializing in her illness: "Uh we were looking on the Internet to find information and then her name came up as the, you know, she's really the pioneer in the research." For both of these women, using the Internet was a joint activity, once again emphasizing the support that their spouse provides.

In contrast, Nirali did not mention the Internet at all when asked about how she learns about health issues. This could be due to a variety of reasons, one of which can be attributed to the short amount of time she has been in the United States. "In India, we did not have a computer in our flat," remarked Nirali, indicating that this technology was not readily available as it is for the other participants who have been in this country for an extended period of time. Although she has been living in the United States for the past couple of years, the Internet is still

not a primary source of information for Nirali, as she is not accustomed to having access to this resource.

Indian Community

The Indian community is another key source of information for these individuals. While this can include the immediate family, it is much broader and often includes a large circle of friends who serve as a family away from home. Although these individuals turn to immediate family first, they also depend on their friends in times of need. Hanuman shared the following story that illustrates this point:

> Then I had some chest pain and I was not for sure if it was anything serious or what, so I called my friend, and asked him to bring some medicine, for some maybe some gas problem, and so I asked him to bring some medicine for me, so he was to bring that, but his son said "no, no…we should not take a chance… we should just call 911 and take him to hospital and let hospital check him out thoroughly". So he says no, we are coming there and we have already called 911, the ambulance is coming there, you get ready and we are going to take you to hospital.

Hanuman not only relied on his friend for help, but trusted in his opinion to go to the hospital. For these immigrants, their circle of friends becomes their extended family and just as important as their spouse, children, and/or siblings.

All of the participants utilized this community for various reasons. For example, this network was used when these individuals were attempting to locate a physician, whether because of relocation or because they were experiencing a health problem. Raj shares:

Internist, ok, first I had an Indian friend here, so he had a friend, an Internist, I used him. Than I wanted some Internist who is affiliated with St. Valley hospital. So I asked him, you know, give me somebody who practicing at St. Valley.

Deepak and his wife also had a similar experience when they moved to the Southeast:

We ask someone, we asked one of our friends when we came to Dougherty and they say ok she's a good doctor. And we went there and aunty [his wife] talk and then oh yeah we know this, this, this. But that is how we found out, ask friend.

Likewise, Jai asked his friends for referrals when he was in need of a surgeon. He notes, "So my friend had his internship at Kaiser so he knows people and he inquired and they told him that this surgeon is good, he is young and good, and so I took him."

A number of participants also mentioned that they discuss health issues with their circle of friends. For instance, Anita shares, "we will be talking you know people our age will be talking about health matters and then we learn little bit from them also at parties or functions or when we visit friends and all that." Similarly, Hanuman notes:

Yeah, a couple of friends that we talk about it, the diet and all that and about what I should eat, what I should not eat, and all that. What they do, and I can learn about it from what they do.

Through these types of discussions, these individuals not only learn about specific topics, but they also encourage one another to practice good health habits. Balram shares one such example that pushed him to continue with his annual check-up:

Then you hear somebody had something you know you start talking about it and people say that's one of those things people should have checked it you know or you should be

checking it. So that brought more vigilance to that one and I said "Boy I should be doing

that religiously." So that just strengthens thought about it you should be doing that one.

These conversations also include dialogue about specific illnesses. Leela voiced her experience

of seeking advice from a friend who had suffered from her same condition:

> Yeah, there is one person, they live here [California] and he's in his um probably 70s and
>
> he developed the condition too and after a while it went away. So I was asking I don't
>
> know he had it all over his hands and eventually it went away and they said he took
>
> homeopathy medicine.

Suresh also revealed how one of his friends provided information when he was having difficulty

with his diagnosis:

> And then I called uh one of my friends, Indian doctor, he was in Dugan and when I
>
> explained to him what happens he right away he figured that it's malaria. So right away
>
> he said you have to come here to Dugan and then I know that the American doctors are
>
> not familiar with that they could not right away tell me what it was.

The participants' network of friends is an integral source of knowledge, providing these

individuals with valuable insight on various health issues. Since the community is close knit, it

was noted that sometimes individuals come together and organize activities for large numbers of

people. One such example was health fairs. "And Gujarat Samaj used to they started, you know

that kind of [health] fair. And Swaminarayan people they wanted to establish something, their

own dispensary hospital or something," shared Hanuman, stating that a couple of times a year

these organizations come together to serve the entire Asian Indian community in their local area.

"Before the health fair start, then they send all the doctors that we have health fair and if you

want to come tell us so we can make a booth for you or something. And they are always willing

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to come to serve the community," stated Balram, expressing the spirit of volunteerism within the Asian Indian community. Since these fairs are completely organized and run by volunteer Asian Indian physicians, these immigrants are more comfortable seeking medical attention. Deepak shared the following:

> They are mostly good because usually we go Indian health fair and all the doctors are Indian over there and they are specialists and you can freely talk to them and everything. They are really concerned you know. They want to do it themselves, give something to the community. So that's why we know that they not just do lousy job. Otherwise they don't come. They don't have to come to the health fair.

This notion of giving back to the community was echoed by several participants and helped to gain their confidence as well as encourage them to seek preventative care.

Nirali was the one exception, in that she did not express the same connection to the Indian community as the other participants. She has not yet developed the extended family like the others have described, and this could be due to the limited time she has been in the United States, having only arrived 2 years ago. Instead, she relied more heavily on her children for guidance, information, and support, as well as her family back in India. "We talk almost every other day and discuss any problems we have," she shared, mentioning that she and her sisters are very close. "My daughters help me with any medical issues I have, such as getting medicine or making appointments." Whereas the other participants have developed familial relations with other Asian Indians in this country, Nirali chooses to cling to her immediate family, whether here in the U.S. or in India.

This section addressed the different resources that the participants used to learn about health matters. This included their healthcare professional, immediate family, and friends. In

addition to this social capital, these individuals also utilized the media and the Internet to stay updated on their personal health concerns.

<center>Asian Indian Cultural Values Influencing Health Behaviors</center>

The next portion of this chapter focuses on the second research question: In what ways does culture and heritage affect this population's health behaviors? These participants revealed that they desired a personal connection with their healthcare professional. When questioned about their doctor visits and treatment process, it was evident that there was a high level of family involvement and that each of these individuals value alternative medicine and consider this form of treatment as an option when they are ill.

Personal Relationship with Physician

Interview after interview, participants echoed the same sentiment: We desire a personal connection with our doctor. This need for cultivating a personal relationship with their healthcare professional originates from their experience(s) with medical treatment in India. For example, Deepak comments, "doctor is part of our family you know. We call them Uncle rather than doctor you know," when asked about his encounter with doctors in India. Similarly, Anita recalls the following, "It was like, everybody knew that doctor, she lived in the neighborhood. We already knew her," noting the familiarity that is already present among doctor and patient in India. Jai shared this story regarding his feelings about the doctor-patient relationship:

> There [India] it is because he knows you from your childhood and it is just like a village doctor who knows everybody and everybody knows the doc and he knows everybody. But here, the experience is like, you go to the doctor and the doctor does his duties and there is no personal rapport.

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This longing for a personal connection is a driving factor when these individuals are selecting a physician. Some feel that an Indian doctor is key to obtaining the desired treatment. Jai notes, "I found an Indian origin doctor, and I said, "I will go to that guy. And he was an extremely nice guy, and he was now his intellectual level as well as on a social." In relation to American doctors, Deepak states:

And uh lot of time you see like American doctor or something we still don't feel like going, because see we feel like they going to ask question, very formal, and we not used to be like that, we want to talk here and there.

In contrast, he is much more comfortable with his Indian physician:

He's like friend, I just went last week, two weeks ago and uh for check up, Dr. Nag, and he's from same city. So I didn't know him before until Dougherty County send him. I didn't know him personally, you know, we knew his name but then he was from same Ahmedabad, same town, and we talked about it.

For these immigrants, there is a strong need to connect, and having a doctor of Indian origin helps to break down the barrier of communication. In fact, nine out of the eleven participants have an Indian physician.

In addition to favoring Asian Indian doctors, still others are willing to make sacrifices in order to find a personal connection with their healthcare professional. For instance, Suresh noted that he drives over a 100 miles to see his physician. When asked why he chooses this commute, he shared the following:

See him, I can talk to him a little closer and you know personal I can call anytime and he can call me. That way a little closer than some outside doctors I guess. That's why it's more a personal thing. Right, as a friend I feel more comfortable.

Leela is also willing to relinquish certain conveniences in order to cultivate a relationship with her doctor:

> Even if I go there and I have to wait an hour I don't mind because I know she [her doctor] takes the time with the patients you know. She's really nice. But she really sits there and make sure all my questions are answered and you have anything else. You know she takes her time which is good.

These stories illustrate that forming a personal connection with their healthcare professional is a necessity for these immigrants and they are willing to do what is necessary to find a physician that is willing to provide this type of relationship.

This desire to connect with the healthcare professional also influences communication between the doctor and patient. These participants not only wanted to feel comfortable asking questions, but they also wanted dialogue with their physician. For instance, Jai shared the following:

> And doctor being a young doctor, he was very cordial and also he knows that I am highly educated, so the conversation between he and I were at a high level…. So it is not like he was telling me and I just accepted, or that I asked dumb questions, or anything like that… it was an intellectual conversation.

Jai was emphasizing that by developing a relationship with his physician he was able to not only voice his opinion, but also be a part of the decision making process. Raj also shared this sentiment. He noted, "So, uh, we [he and his doctor] discuss pretty openly. Then decide what we want to do. He's uh, he don't impose. He gives the choice and discussion and uh then he will explain what's good and bad and why he's doing that." Just like Jai, Raj also appreciated having the opportunity to have an open dialogue with his physician and make decisions together. By

building a personal relationship, these immigrants felt greater rapport with their healthcare professional and thus had increased confidence in the treatment process.

High Level of Family Involvement

In addition to cultivating a relationship with their doctor, these individuals also include their family in their medical decisions and treatment. This value is yet another one that originates from the participants' experiences in India. When sharing her story about her hospital stay, Anita commented, "But you have a lot of support in India. That is the only difference I can think of." Here, Anita was referring to the extended family support that is available in India and absent for many of these immigrants in the United States. For this very reason Deepak's wife returned to India to have surgery: "And uh she wanted to go over there, mother, her whole family. She's more comfortable with her mother and uh after surgery she needed some rest and she couldn't get it over here because nobody was here." When visiting India, Nirali also looks to her family for guidance and support, relying on her brother and sisters when dealing with health matters. "They take me there [the doctor's office]," she says, "especially for blood sugar I go, because my mother she had diabetes. So all of us, all my sisters, once at least we go for check-up." In this instance the whole family goes together to monitor and maintain their health.

Although this type of support is diminished in the U.S., these individuals still attempt to include their family in their treatment process. A number of these participants take a family member with them whenever they visit their doctor. For example, both Suresh and Hanuman note, "Basically my wife was with me going to the doctor's office" and "Or sometimes my wife comes… but mostly we go together." In a similar fashion, Jai commented, "I went with my wife… because wife is also involved in this thing, so she has to know and it should be a joint

decision." While in the United States, Nirali relies on her daughters for support. She shared a story detailing a time when she utilized her family to help her husband:

> I rang up to my daughter saying that you take appointment for the evening so that we can take daddy there. Then my daughter and then my son-in-law consulted each other from their office only, but they said, "No, when he's saying chest pain don't wait till evening. Why to take any chance like that so it is better uh I will go home my son-in-law said I will go home and then take him to any doctor that is um near our place."

Nirali trusted the judgment of her daughter and son-in-law in the treatment of her husband. In addition to this trust, older Asian Indian immigrants often relinquish decision making to their family. Leela shared one such story:

> They don't tell you even if you're dying they won't tell you're dying. Basically they tell the family but they don't tell the patient per se. That kind of and then they leave it up to the family I think. Like one of my brothers-in-law he has um cancer in his intestine. So then but the kids never told my brother-in-law he had that, so you know he doesn't have to be on medication or anything and now he's able to retain food and he thinks he's ok now. Well there is always that chance, why worry him with that?

This is another illustration of how these immigrants not only look to their family, but often rely on these individuals to make critical decisions.

Valuing Alternative Medicine

When considering medical treatment, whether on their own or with their family, all of these participants mentioned that they have contemplated the use of alternative medicine at one time or another. These individuals firmly believe that this form of medication has value for a variety of reasons. Family plays an integral role in this belief. For example, when questioned

about his interest in alternative medicines Deepak stated, "Yeah, they believe, and now I believe too," noting that his family's confidence in this form of treatment influenced his decision to try this type of medication. Likewise, Balram's experiences in India prompted him to continue alternative treatments in the United States:

> I mean because whatever was in India what they used to give us for medication uh you know if you have a cough they give you a little turmeric in the milk, they warm it up and give you in the evening. Yeah, I believe in those things. All the ayurvedic things, homeopathic, ayurvedic, anything like those home remedies you know?

Others utilize their own understanding of the system as reason enough to try alternative medical treatments. "Ayurvedic is plant based and natural and they have been dispensing these ayurvedic medicines for, in their families, for so many generations, so the knowledge base is there," described Jai, explaining why he believed this medical system has value. In a similar fashion, Babu shares his thoughts:

> Yeah, it may have some uh active ingredients in the Ayurvedic medicine. But you know by and large if you take Ayurvedic medicine you know for most part what I believe it gives a lose motion you know, clean out the system.

Here he notes the long term usefulness of this medicine, which allows individuals to maintain a healthy body over time.

Even those who have limited experience with Eastern treatment expressed their belief in this medical system. "If I had started homeopathic medicine and it was controlling my health well, I would have continued that," shares Hanuman. Similarly Suresh mentioned:

So I guess if things didn't work for me I would go to the other ways [ayurvedic and/or homeopathy] to get better. I don't mind going to the others if this didn't work then I have to try something else.

Jai also shares this sentiment. "If the Western medicine says that is all we can do, and the other [Eastern medicine] says no, no, we have this, then I would go and try that," he says, adding that he would not "discard that option" simply because it may not be his first choice. Each of these statements demonstrates that even though these immigrants may not currently be using Eastern medicine, its value is not mitigated and this form of treatment is still a consideration when they are confronted with an illness.

Surprisingly, even though Nirali just recently came to the United States, she stated that she has "never used Ayurveda or Homeopathy. This could be due to family influence. "My brother and sisters are strong believers in allopathy [Western medicine]," shared Nirali, indicating that she often seeks their advice when she is in need of medical treatment. This is another example of how family plays an integral role in the decision making process for these immigrants. However, although Nirali has not utilized Eastern medicine for herself, she did mention that she tried it for her husband when he was ill. "Homeopathy, yes, I tried because this was not suiting him this dopamine medicines they were not suiting him for a long time. Then I thought alternative medicine why can't we try?" she stated, indicating that while her own personal experience with this system of medicine was limited, she still understood and recognized its value.

This section explored three different cultural values that influence the health behaviors of these immigrants. First, all of these participants seek a personal relationship with their physician and are willing to make certain sacrifices to develop this rapport. Second, in addition to this

personal connection, these individuals also desire a high level of family involvement in their

medical treatment. And third, these immigrants value alternative medicine and believe in the

benefits this system can provide when they are faced with an illness.

<center>Mediating between Eastern and Western Medical Approaches</center>

This final segment focuses on the third research question: How do older Asian Indian

immigrants mediate between Western and Eastern healthcare approaches? Data analysis

revealed two findings related to this research question: 1) Individuals experiment with both

Western and Eastern medicine and 2) these immigrants adopt a skeptical attitude towards certain

Western medical practices.

Experimentation with Western and Eastern medicine

 Not only do these immigrants consider alternative medicine, but each of these participants had

also used this form of treatment at one time or another. When discussing their decision making

process during treatment it was clear that these individuals experimented with both systems,

resulting in varying patterns of use between Western and Eastern medicine. For example, some

participants choose to start with alternative medicine when they were experiencing a medical

problem. Deepak shared the following:

> And I start taking, not over the counter but homeopathy or something like that. It was
>
> known for prostate, you eat that and it takes care of prostate. For this I forgot name but
>
> there is a special one for the prostate too. So I started taking that. I tried, instead of
>
> going to the doctor.

Suresh also began with alternative treatment when he was first diagnosed with diabetes. "But

my friends they used to um say some of the Indian herbs and some of the seeds uh [in]

vegetables would help to minimize diabetic effect. I used to eat that," he commented, noting that

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he preferred to try this natural remedy rather than take medication. Anita shares this attitude. "Yeah, I really don't like to take medications unless it is absolutely necessary," she said, explaining that she prefers to try other approaches if at all possible, especially if her illness is mild. She elaborates further:

> So if I catch the onslaught of cold or something I try that. I use natural remedy you know for if I have congestion cold or something I may brew some kind of natural tea or something. I just brew myself. Make some kind of brew. Or for indigestion or something, I may use ginger or something like that. I learned about it from India.

Her desire to avoid medication, along with her knowledge of alternative remedies, allows Anita to choose the route of treatment that seems most valuable to her. However, both Suresh and Anita commented that if they are not seeing improvement, they alter their course of action. "The herbs were not properly controlling my blood sugar so I switched to medication," shared Suresh. Similarly Anita noted "If the brews don't work than I will try over-the-counter medicine or see the doctor." Although both of these participants prefer natural remedies, they are willing to use other forms of medicine in order to achieve effective treatment.

In contrast, others described situations where they started with Western treatment and moved to alternative medicine in the hope of better results. Nirali shared one such story regarding her husband:

> This dopamine medicines they were not suiting him [her husband] for a long time. So when we told the doctor they said no that is the only medicine he has to continue he has to bear that. That's what they used to say. Then we thought why can't we go for homeopathy?

Finding relief for her husband was an instigator for Nirali to look into alternative forms of treatment. So, although the doctor felt that the dopamine medicine was the appropriate treatment, Nirali and her husband decided to try homeopathy. "So we tried those medicines, but no significant results. So it [homeopathy] was not troubling him much, but not much progress was there and so we went back to the dopamine medicine."

Leela spoke of a similar situation. She has been struggling with an illness for several years and after becoming discouraged with Western treatments, as well as the physicians, she turned to alternative medicine. She even went to India to visit with a doctor specializing in alternative remedies and is planning to return for follow-up:

I'm going to India again in May so I'll go back to him [homeopathy doctor] and see what he thinks of it. So he's treating me, well I saw him when I was there last year and then he's just sending me medication through the mail every two months.

Just as Nirali was looking to ease her husband's discomfort, Leela also chose this course of action in hopes of finding a solution for her own personal medical problem.

Still others noted that they utilize both Western and Eastern treatments simultaneously, believing that the two forms of medicine complement each other. "So I do that one whenever there is a need, use of lemon, ginger, things like that" shared Balram. But when asked if he starts with these natural remedies he stated, "No, no, no, it's not that I will try that first and then go to something. I will try that one along with other over the counter [medicines] what has worked for me." In a similar fashion, Deepak also noted that he has a particular medicine that he uses on a regular basis. "So like if you have stomach problem for long time then they give *Herda*," which is an ayurvedic medicine that is even available here in the United Sates. He continues, "You can take *Herda* so many days and your stomach clears. So those kind of things I use. It is just long

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term." With this last point Deepak expressed the need to take this medicine along with other over the counter treatments in order to achieve immediate symptomatic relief while he continues with the ayurvedic medication for long term maintenance.

Listening to these stories it became evident that with these participants there was no clearly defined pattern of mediation between Western and Eastern medicine. Instead, the decision was based on each individual's experience, knowledge, and belief in each form of treatment.

Skepticism with certain Western medical practices

As these participants shared their experiences with deciding between Eastern and Western medicine, an underlying belief emerged. A number of these individuals expressed their uncertainty with particular medical practices here in the United States, not only when they first arrived in this country, but also today. For many of these immigrants, the notion of preventive medicine from an early age was a foreign concept. For example, Deepak stated, "Only time you go to doctor for check up is if you have some problem." Only recently, after being hospitalized, did he begin going to regular check-ups. Hanuman also had similar feelings, noting that he used to see a doctor "only if I am sick, with cold, or something like that," beginning annual exams only a few years ago. This late adoption of preventive care is due in part to skepticism, but is also due to a lack of understanding of Western medical practices. For instance, Deepak commented, "At that time, it wasn't like, I didn't know, that actually it's nice to go, even if you're not feeling good, it's ok to go doctor and have physical check-up or something, it would be nice." In a similar fashion, Balram stated "So I didn't go over there [the doctor], I didn't think of it," explaining that the idea of going for an annual exam did not occur to him until he became older and had a better appreciation for the value that these check-ups could provide.

Although all participants now visit their physician for routine check-ups, they still question some of the practices that they encounter. One major concern that was mentioned repeatedly was the idea of too much testing. "When I came over here they say oh yeah go for this test, go for this test and that upset me," noted Deepak, making him feel uncomfortable and reluctant to seek out medical attention. Both Raj and Jai noted this as a key difference between treatment in India versus the U.S. Raj shared this sentiment:

And also in India they don't do all kinds of tests. But here everything they have to do the test, you know they do the blood test the urine test you know and then based on the test results and their knowledge then they decide.

Similarly, Jai commented, "So there it is they look at you and give you medication right away and this guy [in the U.S.] gets all these tests done and then gives you the medicine." Suresh also remarked about the overuse of tests in the United States when questioned about the differences between his treatment in India. He states, "I guess they run uh tests more than necessary here, uh, that's how I feel. They run blood test I guess invariably for everything…they take the blood and test it." While all of these participants have adjusted to this practice, it was evident that this was, and continues to be, a major obstacle for them to overcome in order to feel comfortable with medical treatment in the U.S.

Summary of Findings

This chapter began with an overview of the study participants, their demographics, and a brief description to help identify with each individual. The chapter then addressed each of the three research questions. The first question was: How do older Asian Indian immigrants learn about health-related issues? The data revealed five main resources that these participants use to learn about health matters. They rely on their healthcare professional as well as immediate

family for guidance on locating a physician, understanding a particular condition, or other such issues. They also used the Internet as well as the media, which included TV news, radio programs, as well as magazines to learn about specific health behaviors. Often these sources would prompt these individuals to seek out additional information. Finally, these participants utilized the Indian community, which is composed primarily of their circle of friends, to discuss health concerns and seek advice.

The second question explored was: In what ways does culture and heritage affect this population's health behaviors? Findings indicated three key cultural values influenced these individuals' health habits. First, these immigrants desire a personal relationship with their doctor and are willing to make sacrifices in order to achieve this connection. Second, there is a high level of family involvement during the treatment process, and at times, these individuals even defer decision making to other members in their family. And third, all of these immigrants value alternative medicine and have considered using this form of treatment at one time or another.

The final question examined in this study was: How do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches? The data supports the idea that these participants experiment with both systems, thus resulting in varying patters of use between Western and Eastern medicine. Some participants begin with Eastern medicine while others move toward this alternative system once they have not had success with Western approaches. Then there are those who use both forms of medicine simultaneously, believing that each has its own value and benefit in the treatment process. Finally, as these participants shared their experiences, they articulated their uncertainty with particular Western medical practices, causing them to adopt a skeptical approach to treatment in the U.S.

CHAPTER 5

CONCLUSIONS, DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

The purpose of this study was to explore how cultural values shape the health-related behaviors of older Asian Indian immigrants in the United States. Three questions guided this research. First, how do older Asian Indian immigrants learn about health-related issues? Second, in what ways does culture and heritage affect this population's health behaviors? And third, how do older Asian Indian immigrants mediate between Western and Eastern healthcare approaches? Eleven participants were interviewed for this study. Sample selection was purposeful in order to find individuals who met specific criteria and represented various regions of India. Semi-structured interviews were conducted lasting between one to two hours each. Follow-up contact by email and/or telephone elicited additional information and clarification.

The results of this study revealed five main resources these immigrants use to learn about health issues and three key cultural values that shape these individuals' health behaviors. Additionally, this study highlighted the decision making process these participants use when considering medical treatment.

Conclusions and Discussion

Findings from this study resulted in two main conclusions. The first conclusion of this study is that Indian culture and heritage shape healthcare behaviors of older Asian Indian immigrants. The second conclusion is that informal learning is the primary way these immigrants learn about health.

Conclusion 1: Indian culture and heritage shape healthcare behaviors of older Asian Indian

immigrants.

The first conclusion of this study is that Asian Indian cultural values influence these immigrants' healthcare behaviors. Culture and heritage are interwoven, representing both the tangible and intangible attributes of a group or society that are inherited from past generations, maintained in the present and bestowed for the benefit of future generations (Banks & Banks, 1997). The term culture has many definitions, but at its heart is a shared meaning system that holds a community together and directs the way that they live, interact, and behave. It has been argued that values represent the core of culture, are fundamental, and refer to the tendencies and preferences of a group of people (Hofstede, 1991). For this reason, this study focused on understanding specific cultural values that influence the behaviors of Asian Indian immigrants. Thus, this section explores the following values in particular: (1) Asian Indians are a collective community, (2) they honor a hierarchical system, (3) they value traditional systems of medicine, and (4) they seek a connection between the mind, body, and spirit.

First, Asian Indians are a collective community, valuing relationships with others over individual gain. In another study of Malaysian older adult learners, Merriam and Mohamad (2000) note that among this population, familial and communal relationships existing in harmony are valued above the individual. This is also true among the Asian Indian community, as these immigrants come together to not only maintain a sense of cultural identity, but also to work together to solve common problems.

This desire to emphasize the community over the individual also encourages these individuals to maintain positive relations with others, which shapes the health behaviors of these immigrants. For example, Grewal, Boltorff, and Hilton (2005) conducted a study with South

Asian women to better understand their decision making process when faced with a health issue. These researchers found that these women made decisions about their health in consultation with other family members not only for support, but also in order to maintain a sense of community and personal connection. This was evident in my study as well, as the participants stressed the importance of high family involvement during the treatment process. Several individuals mentioned that family members often accompany them to doctor visits on a regular basis and are involved in the decision making process. Nirali indicated that she and her sisters "all go together" for a check-up in order to maintain their health. By going together, they have a direct support system and are able to help each other decide the best course of action if confronted with a problem.

When examining which family members are included, it was evident that the women relied on their spouse (with the exception of Nirali, whose husband passed away several years ago), while the men often looked to their adult children and/or siblings. The female participants remarked that their husbands have played an integral role in helping them establish good health habits, as well as assisting them in making decisions when they are faced with a medical problem. In contrast, the men mentioned that their children played a more significant role than their spouse. Although research indicates these immigrants often turn to the male elders in the family (Ma, 1999; Pai & Adler, 2001; Roland, 1988), this was not the case for these participants. While sometimes they did request the help of their eldest son or brother, other times they turned to sisters and/or daughters. This could be due to a variety of reasons. It is possible that geography plays a role. For some of these participants, their siblings still live in India and so they turn to other family that are in closer proximity and more readily accessible. Other individuals mentioned that they contemplate other factors, such as education and connections,

when considering who to ask for help. For instance, Suresh shared that although he lives with his son, he sought the advice of his daughter when he was ill because her circle of friends includes numerous physicians and other healthcare professionals. This illustrates the complexity of family dynamics and underscores the importance of the extended family unit.

In addition to family, the participants in this study also relied on their friends, family, and local community and often looked to these individuals for guidance and information, especially in providing them with accurate and updated health information. A number of these individuals depended on other members of this community for a second opinion when they were experiencing a problem. For example, Balram relied on his friends' opinions when his physician recommended back surgery. His friends' confidence, strength, and support helped to ease his fears of undergoing the operation. In a similar fashion, Raj also utilized other members of his community for guidance when he was confronted with cancer. Given multiple options and unsure how to proceed, he relied on the knowledge and advice of his friends to guide him through a difficult process. Just like Balram, Raj also drew strength from the support of his community and network of friends. This commitment of friendship and information sharing becomes cyclical, as individuals continually help one another and further develop their community and its members.

Second, among the Asian Indian population, there is still an adherence to a hierarchy of authority within the community and among its members, which can cause these immigrants to leave the decision making in the hands of family members or healthcare professionals. Sadler et al. (2001) found that Asian Indians have a tendency to defer judgment to individuals who they feel are experts, whether it is the physician or another trusted individual. For example, Leela shared a story about her brother-in-law's experience with cancer and how the physician and his

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family thought it best "not to worry him," choosing not to provide the patient with details about his situation. This gentleman trusted his family and doctor and thus did not question the suggested course of action even though he was unaware of his actual circumstance. Similarly, Choudhry (1998) argues that often Asian Indians believe that it is the physician's responsibility to monitor and guide their health behaviors. Hanuman, Suresh, Bansi, and Nirali all relied primarily on their physician to help them stay healthy. Each of these individuals trusts the judgment of their doctor and believes that he or she will provide them with necessary information regarding their health.

However, while there are times that these participants defer judgment to their physician, this did not overshadow their desire to connect with their healthcare professional, which could be attributed to this populations' desire to develop and maintain relationships with others. Although the literature on Asian Indians indicates that a respect for hierarchical structure may prevent these immigrants from asking questions and sharing their opinions (Pai & Adler, 2001; Roland, 1988), findings from this study challenge this premise. Rather than being timid and docile, these participants worked to cultivate a personal relationship with their doctor so that it would be possible to have an open dialogue. When discussing his physician, Jai notes he was "now his intellectual level as well as on a social," indicating that he is comfortable conversing with his doctor on both a formal *and* informal level. While these individuals still view their healthcare professional as an expert, they also want to be able to talk "here and there," as Deepak stated, providing them the freedom to share their hopes, fears, and concerns.

This need for open dialogue, as well as being included in the decision making process, is an intriguing finding and in contrast to the doctor-patient structure here in the United States. Researchers note that physicians in this country are often regarded as an expert and usually

diagnose in an authoritative, hierarchical fashion, with the doctor dictating treatment to the patient (Chopra, 1995; Pai & Adler, 2001). However, this study indicates that these immigrants not only want to be able to voice their opinions, but they also want to be treated as equals. Once again this is in contrast to the hierarchical nature of the Asian Indian culture (Roland, 1988). Although there is a respect for authority and the physician's expertise, this does not always lead to compliance. Instead, these immigrants prefer to have a relationship where communication flows not only from the doctor to the patient, but vice versa as well. They not only want to be included in the decision making process, but also want to be able to have an intellectual conversation with the doctor, sharing their concerns and also having the opportunity to disagree with his or her suggestions and/or advice. This could be attributed to the high education level of these participants. For instance, Jai noted that he was "a highly educated man" and he desired conversations with his physician that were at this same intellectual level. Similarly, Raj mentioned his background in engineering and how he wants to have a logical discussion when deciding between treatment options. Both of these examples highlight the impact of education on the communication preference of these participants and how this influences the doctor-patient relationship.

Third, although these participants may not adhere to a hierarchical structure when working with their physician, these immigrants still believe in traditional beliefs, such as indigenous medical practices (Channa, 2004). Even today many elders within the Asian Indian community still believe in Ayurvedic medicine, the 6,000-year-old tradition of healthcare from India, which provides individuals with a holistic approach to medicine by connecting the mind and body (Chopra, 1995). Findings from this study confirm that elders in the Asian Indian community still consider traditional systems of healing. All eleven participants had utilized this

form of treatment at one time or another and, more importantly, place value in this system. When considering treatment options, alternative medicine becomes a viable option for these individuals because of their knowledge and faith in traditional healing methods.

This study expands upon this idea of valuing traditional medicine systems by further elaborating on the decision making process that occurs when Asian Indian immigrants are faced with an illness. Findings indicate that these individuals experiment with both Western and Eastern medical approaches when treating sickness. Strong belief in alternative medicine lead some of these participants to start treatment with traditional medicines such as ginger, turmeric, lemon, and homemade brews. Others, such as Nirali and Leela moved to ayurvedic and homeopathic medicine when they were not having success with Western treatments. And then there were those individuals who did not see a need for drawing a distinction between the two systems of medicine. Instead, they chose to use both Western and Eastern treatments simultaneously, believing that each has its own beneficial component. These individuals believe that ayurvedic, and other such alternative approaches, "clean out the system," as noted by Balram, and use this form of medicine for maintaining a healthy body. While the decision making process varied among these participants, what remains is a belief in traditional healing methods, making alternative medicine not only a feasible but also appealing option for these immigrants when they are faced with an illness.

Finally, in addition to valuing traditional systems of medicine, these immigrants also utilize techniques that help them to maintain balance, mentally, physically, and spiritually. Roland (1988) argues that Asian Indians prefer to focus on the present, which was illustrated by the number of participants in my study who participated in yoga. One of the most common forms of yoga is Hatha yoga. Traditionally, this form of yoga is a complete yogic path, including

moral disciplines, physical exercises (for example, postures and breath control), and meditation. By suspending thought and no longer privileging the mind over the body, individuals are able to gain a deeper understanding of their relationship to others (Srivastava, 2001). Numerous participants mentioned this form of yoga specifically, noting not only its health benefits, but also the mental and spiritual satisfaction that the exercises bring.

Hinduism advocates the use of subjective and experiential methods in contrast to empirical methods (Srivastava, 2001). This can be seen in the decision making process described by the participants in this study. Rather than basing their treatment decision solely on scientific knowledge, these immigrants prefer to rely on their own experience, or information provided by friends and family, which results in their experimentation with both Western and Eastern medicine. They begin with one treatment and evaluate the results based on their own opinion and judgment. This form of experiential learning often leads to introspection and self-study that helps these individuals move from an egocentric attitude to a sociocentric perspective (Chakraborty, 2005). As mentioned previously, Asian Indians are a collective community, privileging the development of the group over the individual. Learning from experience not only allows the individual to reflect and alter his or her own beliefs, but than this knowledge is shared with others, thus increasing the knowledge base of the community as a whole.

The experiences that these individuals had in India, their faith in traditional medical approaches, along with their desire for holistic treatment, lead these immigrants to be skeptical of certain Western medical practices, which was an unexpected finding. Research indicates that those of a younger age, lesser education, and lesser income are more prone to be skeptical of conventional medicine (Fiscella, Franks, & Clancy, 1998), but data from this study suggest otherwise. All the participants were over 60 years old, highly educated, and middle to upper-

middle class, and they still expressed a skeptical attitude when discussing their experiences with healthcare in the United States. While this could be attributed to the fact that these individuals emigrated from India, all but one have been in this country for an extended period of time, acculturating to numerous U.S. customs. However, they still remain uncertain and uncomfortable with Western medical practices.

The literature also indicates that Asian Indians are often reluctant to discuss their medical history with healthcare professionals (Ma, 1999; Roland, 1988). Although findings from this study do not directly confirm this sentiment, several participants shared details and experiences that inadvertently expressed discomfort with Western medical doctors. For example, Deepak noted that he and his wife were still uncomfortable visiting American doctors, feeling that the atmosphere was formal and stiff, thus making it difficult for them to express their problems freely. For this reason, he, along with many Asian Indian immigrants, utilize an Asian Indian doctor as their primary healthcare professional. In fact, nine out of the eleven participants in this study mentioned that their primary care physician was Asian Indian. Having a doctor of Indian origin increases the comfort level for these immigrants, allowing them the freedom to share their concerns and cultivate the personal relationship that they desire.

While visiting an Asian Indian physician does improve communication for these individuals, it still does not eliminate all of their skepticism. Even Indian doctors must adhere to specific Western medical norms, which are often focused on the symptoms rather than the individual, and some of these practices are still confusing, and even disturbing, to Asian Indian immigrants because they are contradictory to what they experienced in India. One such practice that was mentioned repeatedly in this study was the notion of testing. A number of participants felt that doctors required too much testing, such as drawing blood, and often did not see the need.

"Invariably they draw blood for everything," shared Suresh, emphasizing that at times this procedure seemed unnecessary. Although these individuals have adjusted to these types of practices and have an understanding of the underpinnings of such decisions, it is still a source of tension, especially if these immigrants are uncomfortable in voicing their concerns with their physician.

Medical skepticism, which can be defined as doubt in the ability of conventional medical care to appreciably alter health status, has been linked to the use of alternative medicine (Callahan et al., 2008). According to the National Center for Complementary and Alternative Medicine (NCCAM), patients often turn to alternative treatment when conventional medicine fails or provides dissatisfactory results, and findings from this study are indicative of this statement. Numerous participants mentioned that they had moved to alternative medicine, such as homeopathy or Ayurveda, after becoming discouraged with the outcome from conventional treatment. With this increase in use, it is critical that physicians question their patients about the use of alternative medicine. Sleath et al. (2005) found that patients were more likely to reveal this information if their doctor used a participatory style of communication. This could be one reason why these immigrants desire a personal connection with their healthcare professional and seek out a doctor with whom they feel will listen and include them in the decision making process. Not only does it allow them to talk freely, but this type of relationship also has the potential to lead to more effective treatment.

Conclusion 2: Informal learning is the primary way these immigrants learn about health issues.

The second conclusion drawn from this study is that that these participants utilize different forms of informal learning when seeking information about health matters and/or concerns. Informal learning is considered to be learning that takes place outside formal

instruction, and it can take place in a variety of contexts (Day, 1998; Galbraith, 1992). Cairns

(2000) suggests that what is learned through this method may be the most significant learning

that an individual acquires, and this is especially relevant when considering health knowledge. A

number of participants shared how a news program, a magazine article, or even a conversation

with a friend, altered their health habits. Deepak noted that an advertisement on the radio

encouraged him to attend a screening and Balram mentioned that information in a magazine

article prompted him to begin annual check-ups. Knowledge gained through informal channels

helped to change these individual's perception about health and stimulated a positive behavior

reaction that ultimately led to long term benefits.

Other researchers have also investigated the context in which informal learning occurs.

English (1999, 2000) suggests that this type of learning is generally unintended, happening on a

continuum of learner consciousness. For example, in this study all participants mentioned that

casual conversations at parties and/or other community functions often led to insight on a new

topic. Although these individuals were not directly seeking information, participants discovered

that informal dialogue with friends and family often resulted in unanticipated learning.

Hanuman recalled that a weekly chat with his sister increased his understanding of vitamins and

even resulted in regular use of one in particular. Similarly, Leela shared how a conversation with

other female friends introduced her to the negative health aspects of dye, thus causing her to stop

coloring her hair. In both of these examples a casual interaction with friends or family became

an indirect medium for knowledge sharing, leading to learning that was unintended.

Since individuals are not directly seeking information, English (1999) argues that for

learning to occur, "there has to be some element of reflection on action" (p. 391). People need to

return to the experiences they have had, reevaluate these experiences, and then decide what they

would do differently. This form of reflection was evident in the decision making process of these participants when they were faced with an illness. The experimental attitude that these immigrants adopted was in itself an informal learning process. They started with one treatment, reflected on the outcome, and then decided whether or not they should take a different course of action. For example, Suresh mentioned that several of his friends have used a particular Indian herb to control diabetes. Suffering from the same chronic illness, and being reluctant to use medication, Suresh also chose to use this natural ingredient to control his sugar level. After several weeks and no improvement, he was forced to reevaluate his decision, as well as his desire to avoid long term use of medications. After much deliberation he recognized the need to modify his treatment in order to improve his well being.

Leela had a similar experience, but in reverse. When confronted with an illness, she started treatment with Western medicine. However, after months of limited success, she began to contemplate other options. She had never used alternative treatments before, but her dissatisfaction with solutions available through Western medicine prompted her to consider traditional, more naturalistic approaches. She read about these other systems of medicine and spoke with friends and family in India who were familiar with Ayurveda and homeopathy. After reflecting on her situation, she decided to go to India and visit a physician who specializes in homeopathic treatment, and is currently using this system in hopes of curing her disease.

In both of these examples reflection allowed these individuals to assess their preconceived notions about health, well-being, and medicine. In addition to this contemplation, interaction with others also improves the informal learning process (Galbraith, 1992). Among Asian Indians, networking is common and often results in knowledge sharing. In this study, all eleven participants mentioned the Indian community as a key resource for information,

especially concerning health issues. For instance, they all made use of this network when they were searching for a physician, whether it be a general practitioner or a specialist for a specific illness. This type of networking most often included the participant's circle of friends and took place in a variety of contexts such as a party, someone's home, or the local temple. It was evident that these immigrants relied on other members within the community, sharing resources with one another whenever necessary. Raj summed it up best by saying "We are *very* fortunate to have the Indian community. We can call anybody and go to anybody when we need help." This form of relationship building leads to dialogue, which in turn results in informal learning.

Informal learning is a complex process which is difficult to measure (Gorard, Fevre, & Rees, 1999) and even more difficult to describe. However, some researchers have attempted to outline the characteristics of this learning process, such as its focus on learner control (Garrison, 1997). Others have adopted a more general description such as a continuum with formal learning on one end and informal on the other (Stein, 2001). For this study, the most useful explanation of informal learning is put forth by Burton and Perkins (2003) who describe this process as "filling in the gaps." This was evident in the numerous resources the participants utilized in learning about new health issues. An individual may hear about a certain topic at a party and become curious, which may lead him or her to have additional conversations with other friends and/or family. For instance, Deepak explained how he heard a news program detailing how President Bush exercises and maintains his heartbeat at a certain level during his physical routine. After hearing this report, he was curious about this idea and had additional questions. Does this apply to his own exercise schedule? How does one calculate his heartbeat? What is its importance? Wanting to learn more, Deepak turned to his friends. Through talking with other individuals, he was able to increase his understanding of this phenomenon by learning

additional information. One friend explained how he can calculate his heart rate before, during, and after exercise, and what level he should maintain at each of these stages. Deepak's daughter used the Internet to show him different equipment that would help him monitor his heartbeat during physical activity. One news program prompted him to utilize other resources to fill in the missing pieces and in turn, changed his perceptions of exercise. Just like Deepak, all of these participants used a variety of resources to "fill in the gaps" in order to increase their understanding of a new idea or issue.

Findings from this study also indicate that these immigrants utilize nonformal learning in addition to informal learning. Nonformal learning refers to organized activities that take place sometimes outside of educational institutions but are located in community-based settings such as local churches, cooperative extension, or non-profit organizations (Galbraith, 1992; Merriam & Brockett, 1997; Merriam & Caffarella, 1999). Heimlich (1993) identified nonformal learning as "any organized, intentional and explicit effort to promote learning to enhance the quality of life through non-school settings" (p. 2). This type of learning is evident in the Asian Indian community. For example, several participants mentioned health fairs, which are coordinated by local Asian Indian organizations and run by local Indian physicians who volunteer their time. These fairs are held at public places in the community such as Indian shopping centers or the local temple. In addition to these health fairs, temples often provide various seminars and classes for the local community. Both of these activities emphasize information sharing and skill building, as well as fostering personal enjoyment (Taylor, 2006). At the health fairs, individuals are not only offered free screenings and check-ups, but they are also provided with information and skills that will improve their well-being. One participant mentioned that he learned how to monitor his diabetes and another shared that she was taught about breast self exams. Seminars at

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the temple range from information about heart disease to lectures on the meaning of religious texts. These workshops not only increase knowledge and skills, but they also allow social interaction for these immigrants. Another participant expressed his fondness for a yoga class at his local temple, not only because of the exercises and meditation he was learning, but also because it provided him with personal enjoyment and allowed him to congregate with friends and family on a regular basis. Just as networking, a mechanism for informal learning often results in community development, nonformal programs within the Asian Indian community also lead to information sharing among its members.

In addition to informal and nonformal learning, this study indicates that these immigrants also utilize self-directed learning. It is argued that self-directed learning is a natural part of adult life (Merriam & Caffarella, 1999) and can simply be defined as learning on one's own. Numerous participants mentioned that they read material on their own to better understand different health issues that affecting them personally or other friends and/or family. They also mentioned the Internet as a primary source of information. "I will go on the Internet just to learn more," shared Bansi, noting that he browses on his own to stay updated on specific topics. As noted by Brookfield (1993), learning on one's own gives each individual primary control over his or her learning, a factor that appeals to many adults. This desire for control may also enter the doctor-patient relationship and provide another reason why these immigrants seek a personal relationship with their physician. It is possible that they want open dialogue so that they can control their own understanding of the phenomenon, as well as the proposed diagnosis and treatment.

Several models of self-directed learning have been proposed, some linear (Knowles, 1975), some instructional (Grow, 1991; Hammond & Collins, 1991), and others interactive

(Brockett & Hiemstra, 1991; Cavaliere, 1992; Danis, 1992; Garrison, 1997; Spear, 1988). The interactive model postulates that information gathered through one set of activities is stored until it fits in with other ideas and resources on the same topic gleaned from one or more additional clusters of activities. This process is evident in this study, as the participants used multiple resources to learn about various topics. Some individuals would go onto the Internet and read some information and that issue would come up later in a conversation with friends and/or family. Others would hear about something of interest in a casual conversation and would then read more about that topic to better understand its details and nuances. Using multiple approaches, these immigrants are able to engage in a sufficient number of relevant clusters of learning activities and then assemble these clusters into a coherent whole.

This section examined two conclusions. First, Indian culture and heritage shape the healthcare behaviors of older Asian Indian immigrants. Four values were explored in detail. And second, is the conclusion that informal learning primarily characterizes how these immigrants learn about health.

Implications for Practice

This study highlights a number of elements that are useful for educators as well as healthcare professionals. First, findings from this research illustrate the informal nature of learning among these participants, and outline the different resources that Asian Indian immigrants use to learn about health issues and negotiate their treatment process. When developing educational programs for this population, it is important to recognize that these immigrants prefer to work in groups, solving problems with others.

The desire to maintain relationships with other members of the Indian community is an integral component to reaching this audience. These individuals look to their network of friends

and family first for information, guidance, and support and through these interactions, there is a form of knowledge sharing that continues to develop the members of its community. For this reason, organizations within the Indian community, such as a local temple, are excellent initial entry points to reach this population. These organizations are a natural gathering place for these immigrants, and can serve as a prime venue for educational programs. In addition, by drawing on this resource it will be possible to not only develop individuals, but also build the knowledge base of the community, which is extremely important for Asian Indian immigrants.

The need to cultivate a personal relationship was not limited to friends and family, but also included the individual's healthcare professional. This finding is critical for physicians, nurses, and other healthcare workers who are treating this population. Research indicates that these immigrants are reluctant to share their medical history (Ma, 1999; Roland, 1988), but this can be overcome if there is a level of comfort between the doctor and patient, which encourages more open communication. Spending a few minutes to learn about each person as an individual rather than a patient will allow these immigrants to develop a personal connection, which is essential when ensuring the well being of this population.

Developing good dialogue with these immigrants is significant for other reasons as well. It is evident that cultural values shape these individual's health behaviors, even those who have been living in the United States for an extended period of time. Traditional systems of medicine, such as Ayurveda or homeopathy, are considered as treatment options by these immigrants when they are ill. Findings from this study indicate that some of these individuals use such an alternate approach in conjunction with Western medicine. This information is vital when offering medical treatment and for this reason, healthcare workers need to not only understand the value that these

immigrants place on traditional medicine, but also establish a clinical atmosphere that will allow this information to be shared.

Taking the time to encourage and develop open communication will also help healthcare professionals address the skeptical attitude some of these immigrants have regarding certain Western medical practices. If individuals are comfortable in engaging in dialogue with their physician, it becomes easier to address their concerns regarding hospital procedures and testing, which in turn will encourage this population to continually seek treatment, whether for a specific problem or preventive care.

Finally, when working with these immigrants, it is important to remember that the entire family is involved in decision making. Data from this study reveals that participants were often accompanied by other members of their family when seeking medical attention, even if the visit was a regular check up. Decisions about treatment options and use of medication were often made in consultation with their spouse, children, and even brothers and sisters. Both healthcare professionals as well as educators should recognize that for this population, the family unit is often a priority over the individual. Physicians should attempt to include the patient's family during the visit, sharing information with all those involved. Similarly, when developing educational interventions, programs targeting the entire family will be increasingly successful, as they will allow individuals to work together towards a common goal.

Recommendations for Future Research

Based on the findings of this study a number of recommendations for further exploration have been generated:

1) This study involved individuals who have been living in the United States for an extended period of time. It would be useful to conduct a similar study with older Asian

Indian immigrants who have recently immigrated to the U.S. to determine if there are differences in cultural values and/or the negotiation of treatment.

2) One of the fastest growing segments of the Asian Indian population is individuals between 25 and 35 years of age (2000 U.S. Bureau of the Census), immigrating to the United States for jobs and/or education. Replicating this study with this audience would help highlight differences and similarities between young adults and elders in this population.

3) Further understanding the decision making process of Asian Indians, especially in regards to their negotiation of Eastern and Western medicine, would help physicians improve treatment for this population. Conducting a narrative study, focusing specifically on how these immigrants choose treatment options, would provide additional details on this topic.

4) This study indicated the importance of family, both immediate and extended, in the health-related behaviors of these immigrants. However, further study could better highlight the dynamics of this familial support. Is the entire family involved all the time? Are there specific individuals who are consulted more often? Answers to these and similar questions will help to better understand these immigrants' support system.

5) This study highlighted several cultural values that influence health-related behaviors among Asian Indian immigrants. However, from this research data, these values cannot be claimed to be exclusive to this population. A comparative study with other immigrant groups (such as Hispanics, Chinese, Koreans, and Japanese) would help to identify values that are unique to Asian Indians and those that are common across immigrant populations.

6) Individuals who were unwilling or unable to commit to an hour-long interview may choose to share their experiences through a survey instrument. A larger sample, which can be obtained through a quantitative study with predetermined questions as well as some open-ended questions, may reveal even more cultural values and learning resources than those determined through the study of 11 participants.

With this study serving as a foundation for further research investigating the role of cultural values on the health-related behaviors of Asian Indian immigrants, it is important for researchers to continue to expand on these findings and conclusions. Doing so will not only benefit educators and healthcare professionals, but also the Asian Indian population.

<p style="text-align:center">Chapter Summary</p>

Based on 11 interviews with older Asian Indian immigrants 60 years of age or older, two conclusions regarding how cultural values shape the health-related behaviors of this population emerged. First, Indian culture and heritage shape the healthcare behaviors of these immigrants. And second, informal learning primarily characterizes how these individuals learn about health. This chapter also addressed the implications for adult educators, program developers, and healthcare professionals. Finally, recommendations were made for possible future studies.

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APPENDIX A

Participant Recruitment Letter

Dear friends,

Hello! My name is Swathi Nath Thaker, and I'm the daughter of Dr. Hrudaya Nath. I am currently working on my Ph.D in Adult Education at the University of Georgia. I am interested in health education, and more specifically, how cultural values and beliefs shape the way that immigrant populations learn about healthcare. For my dissertation, I would like to interview older Asian Indians to better understand how these individuals interact and utilize healthcare in the United States. I am writing to ask for your help in locating individuals who would be willing to talk to me and meet the following criteria:

1. Individuals must be 60 years or older
2. Individuals and their immediate family (which includes spouse, children, and/or siblings) must not be employed in healthcare (doctors or nurses)

I will interview interested individuals for approximately one to two hours about their experiences with the healthcare system in the United States, as well as how they manage their health. Interviews will be audio taped so that I can accurately capture the conversation, but all information shared will remain confidential and pseudonyms will be used whenever I refer to specific passages of dialogue.

I would greatly appreciate your help in locating appropriate participants. If you know anyone that would be willing to talk to me, or if you have any questions, please feel free to contact me via email (snath@uga.edu) or by phone (678.344.7992). I thank you in advance for helping me with my research.

Sincerely,
Swathi

APPENDIX B

Interview Guide

Please tell me about a time when you were sick.

How would you describe your health?

- Has it changed since coming to the United States?

- What are your health habits?

- In what ways do you attempt to ease your discomfort?

What are your views on healthcare?

- What do you do to prevent illness?

- How often do you visit a doctor?

- When would you consult with a doctor?

Please tell me about an experience you had with a doctor

- What made you decide to go see a doctor?

- How comfortable are you talking with your doctor?

- How do you decide what medical advice to follow?

- How does this experience compare to healthcare back in India?

- How satisfied are you with the medical care you receive as compared to India?

How do you learn about health related topics?

- What types of resources do you use?

- How are these similar/different from India?

APPENDIX C

Interview Participant Consent Form

I agree to participate in a research study titled " Understanding the Role of Culture in the Health - Related Behaviors of Older Asian Indian Immigrants " conducted by Swathi Nath Thaker from the Department of Lifelong Education, Administration, and Policy at the University of Georgia (542-3343) under the direction of Dr. Sharan Merriam, Department of Lifelong Education, Administration, and Policy, University of Georgia (542-4018). I understand that my participation is voluntary. I can refuse to participate or stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed.

The reason for this study is to better understand how cultural values influence how older Asian Indian immigrants learn and negotiate health issues in the United States. If I volunteer to take part in this study, the following will occur:

1. I will be asked to participate in one interview that will last approximately two hours. Following the consent form, the researchers will collect demographic information from me by verbally running through a checklist. These activities will take place at a time and location that is convenient for me.

2. In addition, the researchers may ask for copies of journals, calendars, or other documents that identify health related issues important to me to use as research data.

3. The researchers would like to make an audio recording of the interview.

4. In addition, the researcher may contact me 3-4 weeks after you participate to seek clarification or more information regarding your responses.

The benefits for me are that I have the chance to share my experiences and better understand how my cultural values shape how I learn about health. The researcher also hopes to learn how these beliefs can be utilized by healthcare professionals to better serve the needs of older Asian Indian immigrants.

The researchers do not expect any risks for me from participating in this study. It is possible that I may feel uncomfortable answering some of the research questions. I can skip any questions that Ii do not wish to answer. In addition, I may stop answering questions or discontinue participation at any time. If I experiences any distress as a result of my participation in this research, I may contact the investigator or his advisor for other counseling referrals, assistance, and resources.

No individually-identifiable information about me, or provided by me during the research, will be shared with others without my written permission, except if it is required by law. I will be assigned a pseudonym that will be used on all documents. Additionally, any data containing individually identifying information, including the audio tapes, will be securely kept in a locked filing cabinet and/or password protected computer in the researcher's office.   After analysis is complete, the researchers will erase any individually identifying information from the data, remove any links between my name and results, and will erase the audio recordings.

The investigators will answer any further questions about the research, now or during the course of the project.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

_____   _____   _____
Name of Researcher   Signature   Date
Telephone: _____
Email: _____

_____   _____   _____
Name of Participant   Signature   Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu