Health-Seeking Behaviors of Elderly Chinese Americans: Shifts in Expectations

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Purpose: This study reported a qualitative analysis of health-seeking behaviors of community-dwelling elderly Chinese Americans on the influences of family network, cultural values, and immigrant experience in their use of health resources. Barriers to health care, pathway of health care, and adaptation of health care by use of self-treatment and Eastern and Western medicines were also examined. Design and Methods: The investigators used content analysis to obtain themes and key points of focus group interview data (N = 25) to explore the elderly participants' attitudes, values, and practices in their use of health resources. Survey questionnaires in Chinese were used to compile demographic data. Results: Findings suggested a shift from traditional expectations of filial piety to more dependence on neighbors and friends, and a genuine adaptability to combining Eastern and Western health care modalities. Immigration was not proposed by these Chinese elders as an explanation of shifts in expectations for family support or values. Implications: This study has implications for research, service delivery, and policy making for health care of ethnic elderly persons, particularly in addressing structural and cultural issues in access and compliance.

In this investigation we study the health-seeking behaviors of vulnerable, community-dwelling older Chinese Americans in Los Angeles by examining their focus group discussions concerning family network, cultural values, and immigrant experience. Older Americans, in the aggregate, are known to use health services disproportionately more than other age groups, accounting for one third of this nation’s total health care expenditures (Wolinsky, 1994; Wolinsky & Johnson, 1991). In addition, disparities persist in utilization of formal health services between the mainstream population and minority groups, including the older Chinese subpopulation. For instance, Spolidoro and Demonteverde (1998) found that, of all the ethnic groups, Asian and Pacific Islanders (API), including older Chinese Americans, had the lowest rate of participation in services funded by the Older Americans Act during fiscal years 1994 through 1998.

In fact, although Americans overall have grown healthier during the past decade, minority groups did not keep pace with the health enjoyed by White Americans (Garvey, 2002). Structural and cultural factors may contribute to the disparity. Structural factors refer to accessibility, affordability, and availability of services, including lack of knowledge about services, lack of health insurance and other financial resources, and lack of transportation. Cultural factors include English-language proficiency, health beliefs, and acceptance of health services (Damron-Rodriguez, Wallace, & Kingston, 1994; Riedel, 1998; Wallace, Campbell, & Lew-Ting, 1994).

To bridge the gaps in access to health services and to improve the quality of life for current and future elders, health and human service professionals are beginning to address the issues rooted in the growing diversity of this country. However, attention has

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usually been directed to aggregates of ethnic groups but not to subpopulations such as elderly Chinese Americans (Kuo & Torres-Gil, 2001; Tsai & Lopez, 1997). For example, Tanjasiri, Wallace, and Shibata (1995) observed that prior to the passage of the Disadvantaged Minority Health Improvement Act in 1992, the National Center for Health Statistics, the principal health data collection agency of the federal government, did not distinguish research data on Chinese Americans as an ethnic-specific group. Rather, data that included Chinese had been listed in the “other” category, or within the homogeneous “Asian” or API group (Mineta, 1994). As a result, quantitative and comparative analyses on health and human service needs of elderly Chinese population are limited by inadequate data. The use of data in aggregated form can lead to inappropriate service planning that is based on generalized needs, as well as to homogenized health care that ignores personal and ethnic differences (Tanjasiri et al., 1995).

Older Chinese Americans warrant the attention of policy makers and service providers, because this is one of the fastest growing subpopulations in the United States. Between 1990 and 2030, the API aged 65 and older, including the older Chinese, are projected to increase 643%, compared with 91% for the White non-Hispanic population (American Association for Retired Persons & Agency on Aging, 1996). In Los Angeles County, Chinese Americans are the largest of approximately 30 API subgroups. (The term “Asian” or “Asian and Pacific Islander” refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. The Chinese subpopulation accounts for more than 20% of all Asians, according to the U.S. Census Bureau, 2001.) Los Angeles has one of the largest Chinese communities in the United States, with a diverse immigration history ranging from early settlers of 150 years ago to recent immigrants who arrived within the past two decades. The Chinese population has grown 34% in Los Angeles County during the past 10 years to become the largest Asian group in the region (Fields, 2001; Tsai & Lopez, 1997). Of these persons, 8.3% were aged 65 and older (Spolidoro & Demonteverde, 1998). As the number of aging Chinese Americans continues to grow, their need for health care will increase. With today’s restricted health care resources, public policy makers and health professionals need to develop cost-effective, adequate, and culturally appropriate programs for this country’s diverse populations. Thus, it is critical for health care professionals and decision makers to become familiar with the influences on the health-care-seeking patterns of this ethnic subpopulation.

Respect and treatment of parents and elders on the basis of the teachings of Confucius is deeply ingrained in the Chinese family cultural value system (Sung, 2001). The teachings of filial piety prescribe ways of taking good care of older parents by providing for both the mind and body of the parents. To the extent that Chinese family members are exclusively obligated to solve their elders’ problems, they will tend to avoid seeking external help (Kung, 2001). This study explores the dynamic relationship among three cultural factors contributing to the use of health care resources by Chinese elders: cultural familial values, the immigrant experience, and family and friend support networks. These factors are rooted in filial piety, or elder care with respect, wherein family and kin are the primary support networks of the Chinese elders (Sung, 1998). Social changes as a result of immigration and current social trends also have direct impact on this cultural norm of caring for family (Pang & Sung, 2000; Wong & Ujimoto, 1998).

**Immigrant Status**

The majority of older Chinese in the United States are foreign born (Chow, 1999; Spolidoro & Demonteverde, 1998; Tsai & Lopez, 1997) and, thus, immigrants. Chinese adults came to the United States in two waves, and they were described by Guo (2000) as “early” and “new” immigrants. Those who arrived before 1965 were younger on arrival, largely unskilled, and more likely to be isolated from the mainstream culture. The subsequent groups were more educated, sometimes affluent, and often came to join adult children who had thrived in American society. These elders might be expected to have distinct belief systems and patterns of practice on health and healing, based on their knowledge of Chinese medicine and conventional Western medicine, and their experience in adapting to the American health care system (Guo, 2000; Torsch & Ma, 2000).

Using this bicultural model, we define health-care-seeking behaviors as those actions that address health-related symptoms, including seeking help from health care services and using alternative resources, to “prevent, ameliorate, treat, or cope with the symptoms” (Ell & Castaneda, 1998, p.125). Therefore, health resources can be differentiated into conventional Western medical services, such as clinical services provided by physicians and nurses in hospitals and clinics, and pharmacy services, and nontraditional and informal types of health care, such as acupuncture, herbal medicine, Tai Qi exercise, nutritional diet, home remedies, and reading and watching health programs in the media.

In this study, two overarching research questions were posed:

1. How do interactions between family cultural values and immigrant experience influence health-seeking behaviors?
2. How do family and friend networks facilitate or obstruct the use of professional health care when signs of illness occur?
Methods

This study draws on a secondary data set from the University of Southern California Intergenerational Health Research Team (IHRT) combining both focus group interviews and data from self-administered questionnaires for a pilot study of intergenerational communication around health issues. Urban, community-dwelling older residents who had a language preference other than English were recruited from agencies serving Chinese, Korean, and Latino populations. This article reports the analysis of focus group interviews with 25 Chinese men and women aged 60 and older. The descriptive profile of these individuals was generated from survey questionnaire data. (Results of the general questionnaire findings and psychometric analysis of the measuring instrument Short Form 36, or SF-36, are reported separately; see Jordan-Marsh et al., 2002.)

Focus group methodology is an important qualitative research technique that is especially useful in gaining new cultural understanding of patterns of health care use. Participants in focus groups can provide valuable details based on their specific experiences. They can explain their viewpoints, perceptions, feelings, and the reasons for their actions. (Carey, 1994; Krueger, 1988; Strauss & Corbin, 1990). Given the dearth of information on Chinese elders, focus group data are an essential partner to survey research using questions and scales originally designed for the mainstream population.

Data Collection

Older Chinese adults in the Los Angeles area were invited to participate in the IHRT focus groups by a contact person at the Chinatown Service Center in Los Angeles. This agency is the most established multiservice center in the region, providing a variety of health and human services to primarily Chinese-speaking clients. Prior to the focus group discussions, the participants signed consent forms for videotaping and audiorecording. They were then divided into groups according to gender, with trained facilitators of the same gender and ethnicity guiding the discussions in Mandarin. This arrangement was made in order to facilitate more open discussion, as Chinese elderly men and women might feel less inhibited in expressing themselves when they are among people of the same gender. In addition, spouses would not be able to influence each other’s responses when they were in separate groups. The duration of each session was approximately 2 hr. Subsequent to the focus group discussions, the participants completed a self-administered questionnaire, which gathered information such as demographics, acculturation, socioeconomic status, family composition, activities of daily living, communication of health care needs, and health status measured by a prepublication version of the SF-36 Health Survey in Chinese. (The SF-36 is a 36-item short form of the Medical Outcomes Study questionnaire designed as a generic indicator of physical and mental health status. The prepublication translation was supplied by Barbara Gandek of the Health Assessment Laboratory.) Each participant received $20 as an incentive. Records from the Chinese focus groups interviews were translated from Mandarin into English by IHRT researchers.

Descriptive Statistics and Qualitative Data Analysis

In order to obtain a profile of the focus group sample (N = 25), descriptive statistics were generated from the survey questionnaire data by using the Statistical Package for Social Sciences (SPSS, version 10.1). The content analysis of focus group interview data was guided by the two research questions. The videotapes of focus group discussions conducted in Mandarin were fully transcribed in English. Both the videotapes and transcriptions were reviewed thoroughly by a bilingual (English and Chinese) doctoral student and a bilingual assistant. The transcripts were scrutinized for discussion of values and immigrant experiences (Question 1) and role of family and friends (Question 2) related to utilization of health care services. The research team noted constructs that might influence the elders’ use of health resources (i.e., social support networks, family dynamics, cultural values, and barriers to seeking care). Various actions mentioned by the Chinese elders to maintain their health and to cope with health threats were also identified. The two analysts each generated a separate set of categories representing reasons for health care use or nonuse expressed by the Chinese elders in the focus groups. The two sets of categories were compared and discussed to evolve dominant themes. Quotes from the English transcripts that captured participants’ views, sentiments, and opinions were selected to support each theme (Frechtling & Sharp, 1997; Heurtin-Roberts, 2002).

Sample

Table 1 shows a summary of selected demographic characteristics of the elderly Chinese sample that participated in focus group interviews (N = 25). On the basis of the average length of time these elders lived in the United States (10.27 years), their average age (72.05 years), and dialect of preference (Mandarin), we deduced that participants were more likely to be newer immigrants from Taiwan or Mainland China. This is in contrast to other possible groups such as early immigrants or even new immigrants from Hong Kong, who speak mostly Toisan and Cantonese dialects. This homogeneity is likely to be an artifact of the sampling technique, as participants were recruited from only one multiservice center that served Chinese-speaking clients of the greater Los Angeles area.
More than half of the participants were female (56%) and the majority of the participants (80%) were married and living with their spouses; 12% were widowed. Approximately 12.5% were still gainfully employed. The educational level of the participants was fairly high, with an average of 12 years of education. Because most were retirees, most elders had an annual income below the poverty line of $15,000. The focus group data also indicated that most of the elders faced various kinds of barriers when seeking health care, as 71% of the respondents expressed a need for transportation assistance and 76% needed help with English translation during visits with health care providers. These characteristics of the elderly participants in the focus groups provided an important background for the analysis of qualitative data.

### Table 1. Selected Demographic Characteristics of Older Chinese Participants in the Focus Group Interviews

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Focus Group Participants (N = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td>72.05 ± 5.71</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
</tr>
<tr>
<td>Female</td>
<td>56</td>
</tr>
<tr>
<td><strong>Years in the United States</strong></td>
<td>10.27 ± 6.37</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>80</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>12</td>
</tr>
<tr>
<td>Missing information</td>
<td>4</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>12.5</td>
</tr>
<tr>
<td>Unemployed</td>
<td>87.5</td>
</tr>
<tr>
<td><strong>Education (years)</strong></td>
<td>12.12 ± 3.21</td>
</tr>
<tr>
<td><strong>Annual income ($)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;15,000</td>
<td>83.3</td>
</tr>
<tr>
<td>≥15,000</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td></td>
</tr>
<tr>
<td>Need transportation</td>
<td>70.7</td>
</tr>
<tr>
<td>Need translation</td>
<td>75.6</td>
</tr>
</tbody>
</table>

Change in Family Dynamics.—According to their parents’ reports, sons and daughters no longer practiced the classical forms of filial piety of caring for their parents daily until death (Sung, 1998, 2001). On the contrary, older parents and grown children lived apart from one another. The elderly parents experienced a more independent life by living in senior apartments and thus did not have sons and daughters to tend to their daily health care needs, although the children’s help would be solicited when conditions became serious. As presented in Table 2, the following quotes illustrate several elders’ views on their “modernized” relationship with their children (Pang & Sung 2000; Silverstein, 2000):

We all live in senior apartments.

I will not bother my family if I can take care of the problem myself.

[My children] have their own work to worry about.

Only when I get some serious disease will I think about troubling them.

We don’t need them to help for minor problems—only when it is serious.

Our children will definitely be involved when something serious happens to us.

Shift in Expectations From Grown Children.—These Chinese elders did not appear to have problems getting help from their sons and daughters on request. However, they seemed to realize that Confucius’ filial piety requiring reverence and total devotion from later generations would not extend to great-grandchildren. This perception was expressed by one man (see Table 2): “Usually it is all right to ask the next generation (our children) or even the third generation (our grandchildren) to help. I don’t think it is possible for the fourth generation to help.”

Several other men who responded with laughter quickly sanctioned this comment. Another man added, “it is good enough if we can have three generations together.” As life expectancy increases, multigenerational families are more likely to exist and new family norms are likely to emerge. This group of participants did not attribute any of these changes to the immigrant experience per se. There were no observations that filial piety was diminished compared with what it had been before immigration; nor were there any comments suggesting that their contemporaries who stayed in China or Taiwan were the beneficiaries of traditional values.

Shift in Family and Friend Support Networks.—This group of elders belonged to a middle-old group with an average age of 72 years, and a majority of them were still married; thus spouses played the central supportive role. Besides the family, such informal groups as relatives, neighbors, and friends were important in the lives of these elders, especially in the absence of immediate family members. For this sample, unlike traditional Chinese families, the elders

Interactions of Cultural Familial Values and Immigrant Experience on Health Behavior

The first research question pertained to the effects of interactions between family cultural values and the immigrant experience on health-seeking behaviors of the elders. Three major themes emerged from focus group data to address this question: (a) change in family dynamics, (b) shift in expectations, and (c) shift in support networks (see Table 2).
lived in senior housing communities. Those who lived alone appeared to depend heavily on the help of neighbors and friends as well as the management of the senior apartments in times of health problems. With respect to discussion of familial values, none of the participants linked their reliance on those outside the family to their immigrant status. Nor did they complain that elders left behind fared better. The following quotes illustrate the support related to health matters these Chinese elders could receive in their living environment:

<table>
<thead>
<tr>
<th>Themes</th>
<th>Key Points</th>
<th>Representative Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in family dynamics</td>
<td>Grown children practiced modern forms of filial piety by providing help when needed, but not sharing households.</td>
<td>“My family does not live with me.” “We all live in senior apartments.” “My son and my daughter-in-law live far away from me.” “Our children will definitely be involved when something serious happens to us.” “I will not bother my family if I can take care of the problem myself.” “I find a clinic where there is a nurse who speaks Mandarin. I will go and look for her.” “I will walk to the doctor if I can... I only ask for help when I really need that.” “They have their own work to worry about. Only when I get some serious disease will I think about troubling them.” “We don’t need them to help for minor problems—only when it is serious.” “Usually it is all right to ask the next generation (our children) or even the third generation (our grandchildren) to help. I don’t think it is possible for the fourth generation to help.”</td>
</tr>
<tr>
<td>Shift in expectations</td>
<td>The elders tried to take care of their own health problems.</td>
<td></td>
</tr>
<tr>
<td>Shift in family and friend support networks</td>
<td>Spousal support played a dominant role.</td>
<td>“I often talk to my wife while we eat. We know our health conditions very well.” [Everyone nodding and agreeing.] “Relatives who live far are not as good as neighbors—this is an old Chinese saying.” “The neighbors are closer than our families.” “I can count on my neighbor when I get ill.” “We don’t need them to help for minor problems—only when it is serious.” “I will ask my son to drive me if I need to.” “I need my daughter to take me to the doctor and to talk to the doctor.”</td>
</tr>
</tbody>
</table>

Note: Table presents a summary of findings from focus group discussions among the Chinese elders.

Our apartments are all equipped with a pull switch that can set up an alarm to alert the manager, so that the manager will come in case of an emergency.

Influences of Family and Kin Networks on Health-Seeking Behaviors

The second research question addressed the influence of family and kin networks on health-seeking behaviors of the elders. The themes that emerged were as follows: (a) perceived barriers for health care services; (b) ways the family could facilitate health care behaviors of the elders; and (c) ways the family could obstruct health care behaviors of the elders (see Table 3).

Barriers to Health Care.—The results of a focus group analysis revealed various barriers to health care services needed by the Chinese elders. A cultural
reluctance to seek help from outsiders such as health care professionals is one barrier for this group. As several focus group participants have indicated, only when they had exhausted all options within their family and personal networks would they seek help from the doctors.

Besides the cultural barriers posed by traditional values, the Chinese elders also faced various structural barriers to accessing formal health care services. Lacking English proficiency to know about available services and to communicate with available care providers and having restricted mobility were the major concerns of these elders. Further, some elders found the American health care system very confusing and intimidating. They reported that they did not use their Medicare or Medicaid benefits because they did not fully understand the policies and what treatments and medications were covered. Inability to predict the cost of doctor’s visits was a frightening proposition and deterred some of the elders from using Western medical care. Even when they decided to go for medical services, they had to arrange for rides or endure long bus trips through the maze of Los Angeles’ transportation system. While at the medical facilities they had to wait for hours before getting a few minutes of the doctor’s attention. The following quotes expressed these elders’ attitudes toward visiting health care facilities.

Only when it [illness] gets so bad that it disables or threatens your life; otherwise, we will try to avoid seeing a doctor.
We waited from 8 a.m. to 8 p.m. [in the emergency room].
I have problems applying for [Medicare and Medicaid].
I did not know what to do ... and I do not speak the language [English].
I do not have health insurance. ... I feel nervous because I worry about getting sick.
We do not have the money to pay the doctor.

Positive Influences of Informal Support Networks.—The following section shows how families and friends helped or hindered the health care behaviors of the elders. As shown in Table 3, three forms of help were evident: language assistance,
transportation assistance, and decision making. Providing language assistance could help the elders in several ways: communicating with medical doctors, understanding medical terms, and following up on treatment and prescription regimens. Language help was also needed in communicating with the pharmacist and understanding prescription instructions. Assistance in navigating through the complicated medical system and dealing with various insurance policies was another daunting task for elders and their translators.

When you go to a foreign doctor [non-Chinese], you will have to bring someone; otherwise you will not be able to understand the medical terms. Your company can help you ask the doctor questions and make sure you are getting better, and to follow up on the treatment and your prescription, making sure you are following the doctor’s instructions. Language is a big problem. You really need to know about the drug, when to start, when to stop, and what to do when you run out of the drug, and how often you can fill your prescription because of insurance restrictions. When we get our prescription, we need someone to translate since the pharmacist does not speak Chinese.

With regards to mobility, sons and daughters were expected to provide for the transportation needs of the elders. It was interesting that the women in the focus groups asked for their daughters to help more than their sons; the men would ask for their sons to help more often than their daughters. The reasons for these patterns were unclear and warrant further research. Spouses and friends were also important in helping the elders go to the doctors. However, some would also try to go by themselves first before seeking help from others.

Those who had to take public transportation also found it necessary to be accompanied by someone familiar with the transportation system and who could offer emotional as well as physical assistance on route to the doctor. The following quote captured the attention of the researchers to this special form of aid by one focus group member: “Sometimes we need two persons on the bus especially when you are feeling sick. The other person can help find the way and can help us feel more comfortable.”

Another form of assistance by family members was in making medical decisions, usually when the elders’ conditions became serious. Spouses and friends’ opinions were also sought, but children were expected to help make final decisions.

You will discuss with your families or friends before you make the final decision. My son came from out of state to help me decide on the surgery.

I think that our children will definitely be involved when something serious happens to us.

The findings on how family members could facilitate the health-care-seeking behaviors in this older adult sample confirm the importance of family network on health needs. For example, Alonzo’s study in 1986 on care seeking for emergency cardiac conditions showed that family and “lay others” (e.g., friends) could often provide coping resources, especially in transportation assistance, medication acquisition, and advice to avoid ineffective or even harmful self-treatment.

Negative Influences of Support Networks.— Families can also hinder elders from getting appropriate health care. Because the children did not live with their older parents and were perceived as being busy, it was common for the elders to try not to bother them. As a result, the elders would delay seeing health care professionals as much as possible. “We don’t need them to help for minor problems, only when it is serious. My son is too busy with his work; I only need his help when things become serious.”

The delay in help seeking confirmed the reports of Ell and a coinvestigator (Ell, 1996; Ell & Castaneda, 1998), who found that support network consultation could increase the duration between onset of symptoms and the decision to seek emergency care. Inadequate assistance or misguided help from personal network members could also deter optimal use of health services. This path to care through the social support network that characterizes minority families often results in a tendency to present themselves to health professionals at later states of disorder (Horowitz, 1998).

Pathways to Health Care Service Use

A significant theme that emerged from content analysis was the general pathway to health care and the health care decision-making process followed by the Chinese elderly participants.

You are responsible for your own health.
If I am unable to care for myself, I will go to my wife [for help]. If my wife is not able to care for me, then I will go to my son to ask him to take me to the doctor.
I can count on my neighbor when I get ill.
Only when we exhausted all other options to make us feel better, then would we see a doctor.

As shown in Figure 1, the elders would take care of themselves first, and then they would get help from their spouses. Friends or neighbors would fill in at this time, or they would ask their sons and daughters to help. If conditions became serious, then they would go to see the doctors.
Combinations of Western and Traditional Chinese Remedies

The last theme that emerged from this analysis depicted the patterns of health resources used by the elders based on their cultural background and adaptation to their immigrant experience. These include self-care; home remedies; traditional Chinese medicine; integrated traditional Chinese medicine and conventional Western medicine as a form of “alternative medicine”; and conventional Western medicine alone. The following quotes illustrate how the elders in this study practiced self-care, used home remedies recommended by their friends, and also used a mixed strategy of Chinese medicine and Western medicine:

- We use food to strengthen our immunity. We make sure we have good nutrition and do our exercises. Yes [we all use Chinese herbs].
- I used my friend’s ointment for my arthritis [for massage].
- I had to go back to China to treat my lower backache with acupuncture. I cannot find an effective treatment here.
- I trust Western medicine, but I would also try the Chinese medicine [ointment] that his wife [pointing to another man in the group] used since it is so effective.
- Besides Western medicine, you will consider Chinese herbs.

Still there were others who would not hesitate to find the best Western doctors to give them the best health care available. A woman participant even had a son who was a medical doctor. Some men expressed confidence in the “911” response system in emergencies.

- Get the right medicine for your problems.
- I believe in science and doctors.
- My doctor is the top surgeon in the United States.
- My son is a doctor. I don’t go to the doctor; the doctor comes to me.
- Just pull the emergency switch (in the retirement home) ... it is very easy in the U.S.

The results indicated that the Chinese elders had a mixed method of health care. Whereas some of the women used primarily folk medicines, others regularly used conventional Western medicine, and most of them used both forms of medicine. The men, in contrast, seemed more likely to consult both but to rely on their physicians, and one gave an example of advice from an herbalist that was discounted after consulting his physician.

Discussion

In this investigation we used qualitative data from focus group interviews of older Chinese to perform a content analysis of health-care-seeking behaviors in an immigrant culture characterized by filial piety. The results of this study call into question the central supporting role of sons and daughters in the life of Chinese elders. In addition, the elders in this study did not explicitly link their immigration experience to changes in their experience of filial piety or to their health-seeking behaviors. Sung’s studies (1998, 2001) suggest that few middle-aged children in immigrant families can practice the classical form of filial piety where daily devotion to parents is expected. This trend is not only true among Chinese families but also among people of other Asian countries characterized by respect for parents and elders associated with traditional Confucian teachings. We speculate that the responses of elders in this study may reflect greater acculturation than would have been anticipated (Torsch & Ma, 2000), and that a shift from “filial piety” to “filial autonomy” even among older immigrants may be well underway (Silverstein, 2000). A recent report by Dessoff (2001) pointed to a surprisingly high percentage of older Asians (49%) who endorsed this statement: “My children shouldn’t care for me” (p. 6). Although the proportion of Chinese elders holding this value was low compared with that of Whites (72%), African American (68%), and Hispanic Americans (60%), it showed that older Asians, among them older Chinese, were moving away from the traditional expectations from their sons and daughters. The findings from this study support this trend and are consistent with findings on social support networks in the general aged population (Brody, 1998; Ell, 1996; Hays, 1984; Lee, 1985; Lubben, 2001).

We note that the elders in this study were not recent immigrants; nor had they been in the United States for a majority of their lives. All lived in the United States for at least 10 years but less than 20...
years. Thus, they had time to acculturate to the
dominant culture in which they reside, but not so
long as to lose their unique cultural identity or
language. Further, they did not live in the same
households with their grown children and seemed to
pursue their own lifestyle. It was not clear why the
edlers in this study lived in the senior apartments.
Some reasons might be that they want to avoid the
family conflicts that could exist if they lived in
a multigenerational household, and they might not
want to be a burden to their grown children. Studies
have shown that when the children of Chinese elders
adapt to life in the Western society, their traditional
values and lifestyle often change (Pang & Sung,
With the increase in job involvement and their own
nuclear families, the attention they can bestow on
elderly parents decreases. If the older parents
want to be a burden to their grown children. Studies
have shown that when the children of Chinese elders
adapt to life in the Western society, their traditional
values and lifestyle often change (Pang & Sung,
With the increase in job involvement and their own
nuclear families, the attention they can bestow on
elderly parents decreases. If the older parents
continue to assume traditional patriarchal authority
while the rest of the family is adapting to America’s
democracy and individual freedom, the result can
lead to misunderstanding, family conflicts, and a loss
of parental status (Wong & Ujimoto, 1998; Yama-
shiro & Matsuoka, 1997). Health care professionals
can assist older Chinese adults to make plans for
assistance from family members that are realistic.
Exploring existing patterns of support can be
a meaningful foundation for planning when health
needs change. The danger is in generalizing from
stereotypes of Chinese families to planning care for
specific older adults.

Social supports for the elderly population com-
prise a variety of care and services, including
physical and emotional supports; advice and guid-
ance; information and referral; and assistance in
times of personal crisis (Ell, 1984, 1996). The
immediate family, relatives, neighbors, and friend
and family associations provide “informal social
support” in the life of the elderly population; “quasi-
formal and formal support” are provided by civic
and religious groups, and licensed practitioners from
public and private agencies (Aranda & Knight,
1997). The results from focus groups showed the
change from the classic form of filial piety, which
demanded total devotion, to a modern form of
“informal social support.” Health care professionals
can assist older adults to assess the availability of
resources beyond the immediate family.

The elders indicated that they depended on others
to provide transportation and translation for
appointments with doctors. Lack of mobility and
language are two major barriers to access services for
the elderly Chinese (Advisory Task Force on Senior
Issues, 2000; Kuo & Torres-Gil, 2001; Pang, 2001).
Although some medical facilities have added bi-
lingual staff and translators, these are limited to
areas where there is a high concentration of Chinese
population. It is therefore not surprising that many
of the elders were reluctant to visit their Western
doctors. Failure to comply with appointments or
treatment regimes should be examined in terms of
these barriers.

These Chinese elders reported a path to health care
that began with self, moved to family and friends,
and came to health care professionals as a final resort.
Ell and Castaneda (1998) and Louie (1975) have
reported similar pathways for immigrant health-
seeking behavior. Based on studies involving clinical
samples, two distinct features have been identified by
these authors characterizing pathways to health care
service utilization among immigrant populations.
First, social network members play a dominant role
in providing advice, information, decision making
and actual healing practices; second, patients use folk
healers and home remedies before seeking profes-
sional help, sometimes combining professional help
with folk remedies. Louie (1975) described a compa-
rable model in defining and managing illness for
Chinese Americans in San Francisco. Initially, the
individuals determined what their health problem
was by searching for information from various
sources, including cultural, interpersonal, scientific,
folk, and religious sources. Next, they ascertained or
“linked” the information with their own physical
experience. The individuals then tried self-care. If
that was not effective, they consulted with others
recommended by friends or relatives. The last stage
was the actual engagement of particular healing
practices to find a cure. Making the final decision to
seek formal professional help rested mostly with
family members. Although family caregiver’s in-
volved in decision making is not unique only to
Chinese families (Brody, 1998; Ell, 1996), cultural and
structural barriers do hamper their decision to use
external services for the Chinese elderly (Derr, 2002;
Horowitz, 1998). It is not clear why Chinese men in
this sample more readily turned to physicians and
discounted alternative healing and folkways. Because
all of the men had completed high school and most
had some college courses, they might be more prone
to accept modern science and medicine.

There are several limitations of this study, and
one in particular that bears mentioning. The sample
used for this study was purposively selected from
a community service center and therefore consisted of
elders who tended to be physically capable of
living independently and apart from family. Findings
in this light make generalizations to the larger
population of Chinese elders more tenuous and raise
questions concerning the ability of our findings to
fully encompass the experience of elderly Chinese
immigrants. Nevertheless, these focus group discus-
sions reveal an emerging, and perhaps growing,
group of Chinese elders whose traditional cultural
values and health-related practices are shifting
toward to the mainstream.

From the public health perspective, in contrast to
eyear immigrants who had come to this country from
poor villages at a younger age, the older immigrants
studied in this investigation have come from places
where health care systems were fairly well established and where their health care needs had been met successfully. They have a complex knowledge of illnesses and home remedies because they have been exposed to a uniquely modern orientation toward health care that integrates traditional Chinese medicine and Western medicine (Guo, 2000). It is not surprising, then, that many of these new immigrants have mixed strategies for seeking health care.

Because the Chinese elders in our study rely heavily on their families and friends to gain access to medical care, future studies should focus on members of the informal networks and examine their perceptions, practices, and opinions about optimal health care for their elders. Because many older Chinese subjects reported bringing a third person to mediate the patient–provider relationship, greater research is needed to examine the extent to which this mediator takes “the driver’s seat” or allows the older adult to navigate and decide on the route and speed in health care decisions (Coupland & Coupland, 2001, p. 151).

This study also brought out an important source of health care for the Chinese elders—traditional Chinese medicine. To some participants, it was the only form of health care; to others it was used to complement or integrate with Western medicine. Therefore, researchers and health care professionals should consider patterns of use of traditional Chinese medicine, as well as other forms of alternative medicine, rather than focus only on conventional Western medicine.

Finally, we note that there are policy and practice implications to our investigation, particularly with regard to issues of transportation, language, and cultural competency. As a way to improve access to medical providers, information on public transportation services can be provided in Chinese-language newspapers, magazines, and television, and public education campaigns could be designed to educate seniors how to use public and other transportation services for senior citizens (Committee on Communication for Behavior Change in the 21st Century, 2002).

We suggest that cultural competency training for physicians and other health service personnel is needed to improve communication with immigrant patients; such training could be included within procedures for licensure. As much as possible, bilingual clerical staff should be available to provide direct service or translation for their elderly Chinese clients. In addition, the common use of home remedies and mixed healing strategies requires that professionals of all types be aware of, and able to evaluate, such behaviors during their health care interactions. Therefore, health professionals need to have more knowledge of alternative therapies and be able to guide consumers on their proper use, especially when used in combination with Western medical remedies.

Conclusions

This exploratory study has advanced our understanding of the health-care-seeking behaviors of recent Mandarin-speaking Chinese immigrants living in a major metropolitan area. Their residence in community senior housing and participation in the Chinatown Service Center’s programs showed that they were more successful in leading an independent life from their children than many of their peers and predecessors. To this group of elders, neighbors and friends in the community played an important role in their daily life, including the use of health resources. Children’s involvement became secondary, or at least limited as caregivers. This cultural shift in the Chinese family goes against the notions of filial piety, and it appears to be more consistent with mainstream Anglo norms in the region. However, this shift may be similar to those experienced by other immigrant groups in the United States as they acculturate to mainstream norms, values, and behaviors (Burr & Mutchler, 1999). The role of neighbors and friends who become “fictive kin,” or like family members, requires greater attention for us to understand health-seeking behaviors of older adults more generally.

Societal trends reveal that the use of Chinese medicine is no longer unique to Chinese elders or Chinese culture. In fact, Chinese medicine and other forms of alternative medicine have become increasingly popular in general American society (Eisenberg et al., 1998). Our focus group analysis of older Chinese immigrants revealed genuine creativity in their ability to combine Eastern and Western health care modalities. These subjects may foreshadow a new mixed model of health care practice that has wider implications for how health and human services will be delivered in the future.

References


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