Abstract: The United States has experienced rapid growth of the Asian American population in the last decade. People of mixed ancestry are a significant proportion of Asian America. Little is known about the health beliefs and health practices of this extremely diverse population. Thirteen older racially mixed Asian Americans, ranging in age from 48-94, were interviewed in a qualitative study that included questions about identity, health beliefs, and health practices. Narrative analysis revealed a relationship between identity, health practices, and interpretation of experiences with health care providers.

Key Words: Asian Americans, Mixed Ancestry Asian Americans, Identity and Health

IDENTITY AND HEALTH IN THE NARRATIVES OF OLDER MIXED ANCESTRY ASIAN AMERICANS

The United States has experienced recent rapid growth of the Asian American population, which grew by 48% between 1990 and 2000 (Barnes & Bennett, 2002). Although in-depth knowledge of Asian American health practices has lagged that of other racial/ethnic minorities (Bagley, Angel, Dilworth-Anderson, Liu, & Schinke, 1995), there has been exponential growth in research about Asian American health beliefs and practices in the past decade. This article will extend the dialogue on these topics a step further by examining the health beliefs and practices of a group that has heretofore been invisible in health-related studies of Asian Americans; namely, mixed ancestry Asian Americans.

People of mixed ancestry are a significant proportion of Asian America, with almost 14% of Asian Americans identifying themselves as multiracial in the 2000 census (Jones & Smith, 2001). Asian Americans have reported rates of marrying outside their ethnic group as high as 25% (Lee & Yamanaka, 1990), although there is some evidence that out-marriage may be declining with the increase in Asian immigration since the 1980’s (Lee & Fernandez, 1998). As with Asian Americans in general, there is tremendous diversity within the mixed population. Number of generations in the United States, socioeconomic status, race/ethnicity of the non-Asian parent, ethnicity of the Asian parent, and age are but some of the factors making this an extremely heterogeneous group (Hall & Turner, 2001).

There has been very little health research on people of mixed race. Most studies have focused on infants, no doubt because of the availability of parent race on birth certificates. Studies of birth weight in mixed Black/White infants have generally found an association between the race of the mother (Black) and lower birth weights for mixed race infants than for infants with White mothers and Black fathers or two White parents (Collins & David, 1993), with some regional variations (Polednak & King, 1998). A study of rates of neonatal jaundice in mixed Asian/White infants found their bilirubin levels to be intermediate between those of Asian and White infants (Setia, Villaveces, Dhillon & Mueller, 2002). A study comparing the health status of Asian, Caucasian, and multiracial college students found that the multiracial group had more reported health problems (Vandervoort, Divers, & Acojido, 2000). However, in this study, the multiracial group included an unknown number of Hawaiians identifying as multiracial, which may have confounded the study results, since Hawaiians have worse health in general than Asian Americans and Caucasians (Vandervoort et al., 2000).

A study comparing the health and social risks of mixed vs. non-mixed adolescents found the mixed adolescents to be at higher risk (Udry, Li, & Hendrickson-
None of these studies included older subjects, who would be more likely to experience health problems. No studies examining what role, if any, mixed ancestry might play with regards to health beliefs and practices were found in a review of the literature.

This article is based on an exploratory study that included 13 older people of mixed Asian American/White ancestry who were interviewed as part of a larger qualitative study of mixed race identity (Tashiro, 2002). Studying older mixed Asian Americans offers the opportunity to examine the complex pathways through which cultural beliefs and practices are transmitted intergenerationally when the individual is intimately exposed to two cultures. Members of the older population carry within themselves the imprint of all of their past experiences. They may have spent significant portions of their lives in different cultural settings, and/or in the United States during the years when discrimination against racial minorities was legal and pervasive (Takaki, 1993). Older adults have more chronic health problems and have more encounters with health care providers. Older immigrants may be more likely to use traditional healing methods (Pourat, Lubben, Wallace, & Moon, 1999; Guo, 2000).

**FRAMING THE DISCUSSION THEORETICALLY**

There are no theories of ethnicity that fully account for the complicated position of people of mixed race and how mixed ancestry might influence health beliefs and practices. However, I would like to visit Gordon's (1964) classic model of assimilation, because it can provide a framework for discussion of the issues, and because it has been used in studies of the effects of acculturation on health practices (Lee, Sobal, & Frongillo, 2000). According to Gordon's model, ethnic groups pass through a series of steps towards assimilation. The first stage is behavioral assimilation, or acculturation. This consists of changes in cultural patterns of immigrants to those of what Gordon calls the host society. The next, and more significant stage is structural assimilation, which occurs after the ethnic group members have successfully acculturated and can then mingle with those of higher social status. At this stage there is increased likelihood of intermarriage and penetration of all levels of society, coupled with a sense of identity with the dominant group and abandonment of prior ethnic identification.

Gordon's assimilationist approach has been criticized for its over-reliance on the patterns displayed by European immigrants and for not adequately accounting for the situation of those groups defined as racial minorities. Referring to the assumption that structural assimilation is a stage that all ethnic groups will eventually pass through, Omi and Winant contend that, "...this assumption is quite unwarranted with respect to racial minorities, whose distinctiveness from the white majority is often not appreciably altered by adoption of the norms and values of the white majority" (Omi & Winant, 1994, p. 21). In addition, attitudes toward assimilation in different historical periods must be considered. Assimilation was valued when Gordon developed his theory; however, in the decade following its publication, a new premium was placed on ethnic pride and distinctiveness subsequent to the Civil Rights struggle as a result of new social movements such as the Asian American movement (Espiritu, 1992). Yet, the argument has been made that with the current high rate of Asian American out-marriage, particularly among sub-groups like third and fourth generation Japanese Americans, absorption into the dominant group may be possible.

How does this discussion apply to health beliefs and practices? Much of the health research on Asian Americans has focused on acculturation as an explanatory factor for various health behaviors. For example, Gordon's model has been used as an analytical framework for examining the effects of the cultural and structural components of acculturation on health for Korean Americans (Lee, Sobal, & Frongillo, 2000). The Lee and other's study found that levels and types of acculturation had mixed effects on various health measures such as smoking and body weight, but that, in general, greater acculturation was associated with better health. Acculturation has been identified as a factor in the health of other Asian immigrant populations; as having mixed effects for Cambodian immigrants (Palinkas & Pickwell, 1995); as a positive factor in the use of cancer screening by Vietnamese American women (Yi, 1994; Yi, 1998) and Chinese-American women (Tang, Solomon & McCracken, 2001). Studies have documented strategic blending of traditional and Western practices for Lao-Americans (Gilman et al., 1992) and Cambodian immigrants (Capps, 1994; Palinkas & Pickwell, 1995). Korean elderly in Los Angeles (Pourat, Lubben, Wallace & Moon, 1999), and elderly Chinese in New York (Guo, 2000).

The number of generations of residence in the host country is also very important for Asian Americans. Gelfand (1982) discusses the implications for ethnic generational change and the classic differences between first, second, and third generation attitudes toward ethnic heritage. According to this model, first generation immigrants attempt to acculturate, while still maintaining their ethnic roots. The second generation is more mobile, is more assimilated, and its members are more likely to view their ethnicity negatively. For the third generation, a return to the ethnic culture may seem desirable. Again, this model must be viewed in historical context. For example, it applies fairly well to Japanese Americans, whose demarcation into distinct generational groups is related to immigration history. Thus, most of the first generation, or Issei, immigrated to the United States prior to the Immigration Act of 1924, which essentially halted Japanese immigration (Young, McCormick & Vitaliano, 2002). The children of the Issei, the second generation, or Nisei, were coming of age during World War II during the internment experience. The Nisei were more likely to identify as American, and to experience negative associations with Japanese iden-
tity. The third generation, or Sansei, came of age during and after the Civil Rights movement and the Asian American movement, which emphasized the positive aspects of racial and ethnic identity. The post-1965 wave of Asian immigrants and their descendents have experienced very different historical circumstances, which might lead to differing generational patterns.

The mixed Asian Americans interviewed in this study present additional layers of complexity to this discussion, as they were of two different cultural heritages. Some were first generation immigrants, and even those who were born in the United States generally had some exposure to Asian culture through one parent. Yet, they also had exposure to American or European culture through the other parent, and were immersed in American culture for much of their lives. Given the heterogeneity of Asian ethnicity, immigration history, gender, social class, age, and residential history even within the small number of people interviewed, there is no attempt to draw conclusions that can be readily applied to all mixed Asian Americans. Rather, the goal in this article is to foreground some themes and issues that emerged in the data that warrant further exploration. Several case studies will be used to illustrate the complex and intertwined factors of identity, experiences of racism, exposure to other healing traditions, and generation within the narratives of the participants.

METHODS

The study was approved by the Human Subjects Committee of a large academic medical center. Written informed consent was obtained from all participants. All of the participants discussed in this article were of mixed Asian/White ancestry, ranging in age from 48-94. I had originally set the minimum age limit at 50, but a few participants in their late 40s were included to improve the ethnic and gender balance. Most resided in an urban area in Northern California at the time of the interviews, although about half of the group had grown up or spent significant portions of their lives in other parts of the United States or Asia. Asian ethnicities included Filipino, Chinese, and Japanese American ancestry; they were of first, second or third generations in the United States, and included eight women and five men. The family backgrounds of the participants were a mix of working class and professional. A variety of recruitment methods were used, but the most successful recruiting strategy was through word of mouth via my contacts in the mixed race and Asian American communities. For many of the elderly participants in this study, it was important to know someone who could vouch for me.

Participants were interviewed 1-3 times and interviews were taped and transcribed. The interviews typically lasted about one hour, although some lasted as long as 2-3 hours. Most of the interviews took place in the residences of the participants. The study primarily focused on construction of identity, and the results of that material have been published elsewhere (Tashiro, 2002). However, I was also interested in the health experiences, beliefs, and practices of the people in the study, which is the focus of this article. Health-related interview questions elicited participant definitions of health, health problems, health access, beliefs about the causes of their health problems, experiences with health care providers, the relationship of being of mixed race to their feelings about health and illness, and self-care practices. I reviewed the health-related data after the data on identity had been analyzed. As it turned out, a relationship between the identity-related material and health emerged, which will be discussed via the case examples.

Narrative analysis, chosen to analyze the health-related data, looks at the whole text of participant interviews, rather than breaking up the text into component parts (Riessman, 1990). The influence of context and the relationship of power to health and illness, which are core issues when race is a concern, can be discerned in narrative (Kleinnman & Seeman, 2000). Personal narratives can provide insights about the meaning given to life events by the narrator (Widdershoven, 1993), and narrative analysis is a particularly effective methodology for interpreting the experiences and health beliefs of people of color because it does not disengage the speaker from important contextual and linguistic factors (Etter-Lewis, 1991; Mathews, Lannin & Mitchell, 1994). Examining interviews as a whole allowed me to tease out relationships between concepts within each narrative, rather than across them. Most important, examining the whole narratives provided the contexts for the responses to the questions. Because of the small size and great variation of age, generation, ethnicity, gender, social class, and life experiences, it is the relationships expressed and analyzed within each participant narrative that I think are the most fertile and indicative of directions for more exploration through further research.

THEMES FROM THE INTERVIEWS

Within this small exploratory study there were diversities of age, generation, socioeconomic status, education, ethnicity, and gender. Yet, a persistent association between identity, health practices and how participants experienced encounters with the health care system emerged from the data. Influencing factors included experiences of discrimination, socioeconomic status, age, number of generations in the United States, and the extent of exposure to the culture of the Asian ancestral nation. In general, the stronger the association with Asian identity, the more likely participants were to retain some reliance on traditional healing methods, if they had been exposed to them. For those who were U.S.-born, a strong minority identity was associated with a tendency to attribute insensitive treatment by health providers to the dominant culture. I present this analysis through a discussion of several cases. In choosing the cases, I have selected a group that is rep-
representative by generation, Asian ethnicity, social class, gender, and age.

First Generation Immigrants

A subset of the participants were born and raised in China. Mrs. Chiang and Mrs. Lowe, ages 94 and 69 respectively, grew up in western enclaves in China, and became friends while in China. While they share the commonality of being mixed Chinese American immigrants, there are subtle differences in their personal histories which have influenced how they identify and how they manage health and illness.

It is important to understand the conditions of their lives in pre-revolutionary China. The 19th century had witnessed a rapid escalation of penetration of China by the West. This accelerated after China’s defeat in the Sino-Japanese war of 1894, which left it vulnerable and weak. In the aftermath of China’s defeat by the Japanese, the United States, various European powers, and Japan carved up China into spheres of influence through which they could increase their financial domination and economic exploitation (Chesneaux, Bastid, & Bergere, 1976). Foreign domination continued through most of the first half of the 20th century. There was considerable social contact between Europeans and Chinese in these enclaves and a significant number of offspring of mixed liaisons. The term “Eurasian” was applied to these mixed descendants and is commonly used in Asia to refer to people of mixed European and Asian ancestry. Frequently, Eurasians such as Mrs. Chiang and Mrs. Lowe lived in conditions vastly superior to the masses of Chinese peasants. Significantly, the prevailing ethos of that period was that western ways were superior. As a result, both Mrs. Chiang and Mrs. Lowe received a western education and Mrs. Chiang, in particular, stresses that she was raised western style and spoke English in the home.

However, both women were exposed to the use of Chinese herbs and foods as medicinals. Guo (2000) identifies four branches of Chinese medicine: herbal medicine, diet, acupuncture, and exercises such as Tai Chi and Chi Gong. In Guo’s ethnographic study of Chinese immigrants in Flushing, the people he interviewed clearly viewed herbs and foods as core components of the continuum of healing modalities, which was also true for Mrs. Chiang and Mrs. Lowe. For Mrs. Chiang, the experience was conditional on the presence of someone in the home who knew how to prepare the remedies. She states:

When my mother was alive, most times we used Chinese herbs. And after she died, our cook knew what to do, he knew what to make for me. But after he retired, then I didn’t take any more Chinese medicine. We had American doctors, English doctors, French doctors, you know. Only when I was young, did we use the herbs. You know, whenever I had a cold, certain type of herbs were very good.

Mrs. Chiang’s access to traditional Chinese remedies was contingent on having someone in the household to prepare them. Her socioeconomic status meant that her family was able to have servants, but apparently her European father felt little incentive to continue to provide her with access to Chinese remedies after the death of her Chinese mother, and the retirement of the knowledgeable cook. In addition, because of her social class, mixed ancestry, and the prevailing ethos of western superiority, medical doctors were seen as desirable and were accessible to her.

Apparently, it was not uncommon in Eurasian households for the Chinese servants to prepare remedies for the sick. Mrs. Chiang’s friend Mrs. Lowe describes a post-partum remedy prepared by her servant.

After birth, my servant came with this food, you know, they cook pork with hard-boiled egg and ginger. She told me to drink this, it’s good for you because it gives you a lot of milk. I did, and that’s exactly the way it worked.

Unlike Mrs. Chiang, Mrs. Lowe has continued to use Chinese medicine in the United States, although she mixes it with allopathic medicine. As with the immigrants interviewed by Guo, she relies on allopathic medicine for more serious problems; for example, if she or her children ran a high temperature, she would take them to a western doctor for antibiotics. However, she also uses Chinese methods to supplement western medicine. For example, she went to an acupuncturist for a back injury after seeing an orthopedist who told her she’d be crippled within five years. As a result of the acupuncture, she was almost completely healed, which she attributes to her Chinese heritage. Thus, there is a way in which her health beliefs are inextricable from the Chinese part of her cultural identity.

In addition to their age differences, there are some differences in how these two women self-identify. Mrs. Chiang stresses that she was brought up “western style.” Although she identifies as Eurasian, she says that culturally, she feels western. Mrs. Chiang denies any experiences of discrimination as a Eurasian and stresses that her family made a point of speaking English in the home. Mrs. Lowe, unlike Mrs. Chiang, worked outside the home, where she encountered persistent job discrimination because of her Chinese ancestry. She grew up speaking fluent Chinese, in addition to French and English. She made it clear that she identified as Eurasian, not western. Having had more experiences in which she was identified as Chinese and treated unfairly, she has internalized more of that identity. In turn, she relates that identity to the success of acupuncture on her body. She identifies culturally as Eurasian, not western. For both of these women, there is a parallel between the degree of identification with their Chinese heritage and whether or not they have continued to use Chinese healing practices. The factors influencing Mrs. Chiang’s identity as western are intertwined with those
which have influenced her health practices, namely, being in a household where westernization was viewed as better, a view which extended to healing practices.

Second Generation

**Identifying as American.** Only one of the people whom I interviewed identified primarily as Caucasian or "American." Mrs. Grant, a 76 year old retiree of mixed Japanese American ancestry, says that she identifies as Caucasian because that's what most of her friends are, that it reflects how she was brought up, and that she basically thinks of herself as an American. Although her father was from Japan, and she lived in Japan for several years, Mrs. Grant says that both parents wanted their children to be Americans. While in Japan she attended a Canadian school, spoke English and ate American food. Her father was a businessman and the family was quite well off. Mrs. Grant and her sisters were sent back to the United States before World War II, and they remained in the United States.

Although Mrs. Grant says she experienced tension during World War II, since she was living on the East Coast, it was less virulent than what was experienced by people of Japanese ancestry on the West Coast. She was also protected by her socioeconomic status. She denies being exposed to any traditional Japanese healing methods in Japan. Mrs. Grant's narratives about her experiences with her health and the health care system are devoid of references to her Asian heritage, correlating with her identity as Caucasian.

**Discrimination, Poverty, and Identity.** Mr. Pimental, who was 57 at the time of the interviews, is a second generation, working class mixed Filipino American. His family history is replete with the dual impacts of racism and poverty, beginning with his parents. According to Mr. Pimental, when his White mother married his Filipino farmworker father, the mother's family had his father imprisoned and charged with "White slavery," refusing to drop the charges unless the marriage were annulled. Mr. Pimental's mother agreed to annul the marriage, but didn't follow through after her husband was released. The family grew up in poverty with very little contact with the mother's more prosperous side of the family. As a result, Mr. Pimental considers himself to be Filipino first and foremost, then mestizo (mixed), but emphasizes that he is Filipino first, plus something else. He also identifies strongly with his working class background, and a persistent relationship between race and social class emerged in his narratives about health. An example appears in how he describes his encounters with dental professionals as a child:

> There used to be a health clinic for poor people to get dentistry. And it was absolutely an atrocious place. And I remember how the dentists and the nurses used to treat us when we'd come in there. All poor people, all different colors but all poor folks. And you'd leave there swearing you'd never go back because they used to hurt you. I'm telling you, they used to hurt you...How could I explain to my mother that this White doctor and this White nurse treated me like shit?

In Mr. Pimental's narrative, we see the intermingling of class and race. The poor people were of "all colors", but the doctor and nurse were "White." The way he uses the term "White" is not just as a marker of color, but about authority, position, and attitude. Class dominance by those with power is racialized in this narrative. Clearly there is a way that the combination of growing up in poverty with racial discrimination has amplified Mr. Pimental's association of whiteness with poor treatment by people of a higher status. The dual identities of being non-White and poor enhance each other.

Mr. Pimental associates his experience of bodily pain with the whiteness of the health care providers.

Mrs. Soriano, 65 years old at the time of the interviews, is a retired woman of mixed Filipino/White ancestry. She was born in the United States, but spent a significant amount of time living in the Philippines. Mrs. Soriano's Filipino father and White American mother met when they were college students. Due to the antimiscegenation laws in their state, they had to travel to another state to marry. Like Mr. Pimental's family, Mrs. Soriano's family experienced poverty and racism and her mother was also disowned by her family because of her marriage. Her parents had difficulty obtaining work and housing and her Filipino father was subjected to race-based attacks. At the age of six, Mrs. Soriano and her family went to live in the Philippines to escape the racial violence directed towards her father. She returned to the United States with her mother and siblings after the war ended, leaving her father behind in the Philippines. As a family with racially mixed children, the discrimination did not cease on their return. For example, at one point Mrs. Soriano's mother, after repeatedly being refused housing because of her racially mixed children, had to pretend that she had adopted her own children as a missionary so that she could obtain housing.

All of these experiences have affected Mrs. Soriano's sense of identity, which to her is Filipino or Asian. She has internalized her ascribed identity; that is, the identity that others "put on you" (Tashiro, 2002). There was a direct relationship between the internalization of ascribed identity and the amount of negative treatment based on that identity for most of the participants in the study, which is consistent with social identity theory in social psychology (Tajfel, 1981) and sociology (Goffman, 1963), in which stigmatized social identities are the ones most likely to become incorporated into individual identity. This was particularly pronounced for the mixed Filipinos in the Asian American group.

There is a relationship between Mrs. Soriano's sense of identity as a minority, her attitudes towards health and illness, and how she views Western health providers. While in the Philippines, she was exposed to several commonly used traditional remedies. She describes
her paternal grandfather in the Philippines as “a healer, a curer.” She mentions a variety of remedies that she learned in the Philippines, including ginger for the stomachache, aloe for burns, massage, and several plants that she says are insulin precursors, for diabetes (she has adult-onset diabetes and heart problems). Mrs. Soriano balances the use of traditional remedies with allopathic medicine, although she considers Western medicine to be “invasive.” As with several of the participants, there’s a sense that Western medicine is reserved for the times when you need the “big guns” and even a sense of its potential danger, similar to Asian immigrants in other studies (Capps, 1994; Guo, 2000). She doesn’t shun allopathic medicine entirely; in fact, she and her husband travel weekly to a suburban hospital to participate in a program for cardiac patients based on the Ornish model. However, Mrs. Soriano is really not comfortable in the program, and she makes repeated references to culture and ethnicity in her complaints about the program specifically and Western-trained health professionals in general. Here she complains about the food in the Ornish program:

They're highly competent people. But they couldn't seem to recognize that their food was giving me a stomachache...It's very difficult, because you recognize that the majority, the dominant culture, is a hodgepodge of European, American etc. The rest of us - we're a minority wherever we go...And it shows up in everyday situations, like the hospital, the institutions are blind. It's true, we all have a liver, and we all have a pancreas. We have physiological commonalities, but culture is a different issue. But that's not recognized. And I resent it deeply because I am who I am. And I pay the fee and I participate in every other way, but they don't need to destroy my body with their food.

Although Mrs. Soriano is of mixed Asian and White American ancestry, she clearly distinguishes herself from the “majority, the dominant culture.” She then goes on to identify herself as part of “the rest of us” who are a “minority wherever we go.” Her lifelong experiences of discrimination have influenced her in the direction of identifying with the minority side of her ancestry, which in turn gives meaning to the way she experiences her encounters with indigestible food. She attributes it to cultural insensitivity and Western hegemony. Her use of the phrase “destroy my body with their food” implies a kind of cultural violence in which food is the weapon.

Third Generation
Third generation participants were unlikely to recall the use of traditional Asian health practices in the home. Mr. Daly, a 50 year old third generation mixed Japanese American claims he had little exposure to Japanese healing practices. He expresses a greater range of ways of identifying than some of the older participants, and these ways are less specifically ethnically oriented. He says that his sense of self doesn’t have much to do with race. Although Mr. Daly’s mother was sent to an internment camp during the war, it was before he was born and she shared little about that experience with the family. He emphasizes that he didn’t have much exposure to Japanese culture and that his family was American, assimilated, “modern.” He lacked Asian American role models and did not identify with the Asian American movement. Mr. Daly’s strongest identification was with the counterculture, with being “cool,” a rebel, an outsider. The cool role models he mentioned were White, like James Dean and Elvis. Yet, when he asked him how he’d identify in racial terms, he said, “Well, I mean, I’m definitely brown, okay. I don’t identify with White. I know I’m not White. I think I identify with being Asian.” However, within the same interview, he states:

And in my adult life, I think I identify more with the Irish in me than I do with the Japanese in me, because that’s what I feel. I really feel more like an Irish person than I feel like a Japanese person in spite of what I look like.

Mr. Daly experiences a variety of dimensions of identity (Tashiro, 2002). The reasons Mr. Daly says that he feels more Irish are that he’s a lot like his Irish American father, in that he is verbose and likes to drink, and, that he speaks English, not Japanese. Yet, it is interesting that while he says he feels Irish, he also says he never feels White, and that one of his identities is “brown.” There is a difference between ethnic identification and racial identification for Mr. Daly.

Mr. Daly describes his parents’ approach to health care as “Kaiser-Permanente” by the book. That was the way to go.” He doesn’t recall any self-care practices from his youth. However, after relating how his father developed complications from a prescribed medication, he states:

...so for people that are born and raised with conventional medicine, I don’t think that it’s the end-all anymore, and I distrust doctors like the plague. How many times have you heard about people going to a doctor to get minor surgery or some minor procedure and they get dead because some bacteria or somebody shoved too much of this and that into them, so I stay the hell away.

Mr. Daly will use remedies from a local health food store, like Echinacea for sore throat, to manage minor health concerns. The self-care measures he uses are fairly common among mainstream Americans. His relationship to self-care measures and attitudes toward health do not depart significantly from many other non-Asian residents of the Northern California community where he resides.
DISCUSSION

What can be learned from this exploratory study? Importantly, the participant stories show us that Asian Americans of mixed ancestry should not be viewed as a homogeneous group. While all of the participants in this study superficially shared the same “racial” backgrounds, this was of little predictive value in terms of their health beliefs, practices, and interpretations of their experiences with the health care system. Taking a closer look, some of the significant influencing factors included the degree to which they had experienced racial discrimination, their socioeconomic status, degree of exposure to alternative healing traditions, and number of generations in the United States. Most of these factors were also linked with identity.

People in the study who were exposed to other healing traditions might discard them or used them selectively, organizing the use of differing belief systems into a typology that worked for them. The ways they retain or discard healing traditions seem to parallel how closely they identify with their Asian heritage. For those participants who experienced intense racism in their lives, there is a tendency to identify primarily with their Asian heritage, particularly when coupled with low socioeconomic status. Those who experienced racial discrimination tended to racialize, that is, to make race (or culture) the primary explanatory factor for poor treatment by health care providers. For those who did not recall much racial discrimination, there was more of a tendency to identify as American, and to not explicitly reference race in relationship to health care.

This study raises question regarding the relationship between identity, health practices, and interpretation of experiences with health care providers. The relationship between how this group of older mixed Asian Americans experience identity and how they relate to health is intriguing and has broad implications for the care of people of mixed ancestry as well as other populations. There is a growing literature that examines the relationship between racial identity and health practices (Johnson, 2002). Much more research is needed in this domain, particularly for people of mixed ancestry with their complicated identities. Many questions need to be addressed in future research on the complex relationship between identity and health behavior. For example, do the experiences influencing identity formation directly influence the domain of health practices and the interpretation of health experiences? Or does identity affect health independently?

This study shows the importance of the context of people’s lives; of history, place, and social experiences that shape the meaning given to encounters that health providers might consider routine. It provides a rare opportunity to witness the lived experience of mixed race. It alerts us to the fact that the people health providers encounter in practice are constantly making meaning out of their experiences through the prisms of their histories and identities.

The results of this study are mixed with regard to Gordon’s model of acculturation and assimilation. Some of the participants, such as Mrs. Lowe, did seem to be culturally assimilated in relationship to their health practices. In Mrs. Lowe’s case, her westernized identity and lack of available practitioners contributed to her discontinuation of traditional Chinese remedies. However, most of the participants in the study who had been exposed to alternative health practices in their families retained some of them, and blended them with allopathic medicine. Experiences of racism directed at their Asian ancestry seemed to reinforce an Asian, or at least a non-White, identity. This, in turn tended to result in racialized interpretations of negative health care experiences. Regarding structural assimilation and intermarriage with members of the host society, several of the participants in this study described the opposite for their parents, with their White parents being ostracized by their families and subsequently being absorbed into the ethnic community of the non-White parent, not the reverse. The extreme character of U.S. racial definitions has tended to place anyone with ancestry not considered to be White on the wrong side of the color line, with its attendant second-class status. This was particularly true when many of the older participants in this study were young. Thus, we see the limitations of the ethnicity model for its inadequacies for those populations considered to be racial minorities. The racialization of mixed Asian Americans is clear in many of the stories of the participants.

In relationship to the characteristics of first, second, and third generations, some differences deserve mention. Because of their mixed ancestry, the immigrants in this study had much more exposure to Western culture than the typical Asian immigrant. They were already fluent in English and had been exposed to allopathic medicine. With the second generation, we see a mixed response to their Asian ethnicity. Some identified primarily as American, and used standard allopathic medicine. Those who had experienced intense racism and poverty tended to identify more strongly with an Asian or minority identity, and to feel a sense of alienation from health professionals based on perceived racial or cultural differences. They were also more likely to use self-care measures and maintain a degree of distrust of allopathic medicine. The third generation participants tended to display multiple and more contradictory dimensions of identity. Their health practices did not differ appreciably from those of the mainstream, which in the case of the locale where the research was conducted, included reliance on alternative self-care measures.

This study is limited by its small size and the challenges of recruiting a representative sample, in addition to the possible confounding of influences like gen-
eration and Asian ethnicity. For example, all of the first generation immigrants interviewed were of mixed Chinese ancestry and each of the third generation participants were mixed Japanese Americans. This problem is in part reflective of Asian immigration patterns to the United States over the last century. A larger study would permit further refinement of the influences of age, generation, Asian ethnicity, gender, and socioeconomic status. There is also a need for studies of additional mixed Asian sub-groups, as the population of Asian American is being transformed by changing patterns of immigration. This study included mixed Chinese, Japanese, and Filipino Americans. The prevalence of these subgroups in the older population reflects past U.S. immigration practices. Since 1965, there has been significant growth in immigration of other Asian populations, such as Koreans, Southeast Asians, and South Asians. As these populations age and intermarry, their mixed children will be faced with an entirely different set of historical circumstances shaping identity. More studies on people of different ages are needed to determine whether different age cohorts experience mixed ancestry differently. I would also like to see a study comparing different generations of non-mixed Asian Americans with those who are mixed in order to distinguish which of the findings are particular to the multi-racial experience as opposed to just being Asian American.

CONCLUSIONS

The older mixed Asian Americans described in this exploratory study engage in a variety of health practices and interpret their health care encounters differently, based on life experiences. There is a relationship between identity and health practices for those who spent significant portions of their lives in the country of Asian ancestry. Socioeconomic status, generation, and experiences of racial discrimination appear to influence attitudes towards health care and health practices.

Footnotes

1. When the term “mixed ancestry” is used in this article, it refers to those Asian Americans whose ancestry also includes a U.S. defined racial group not considered Asian, i.e., African American, White, Native American/Alaska Native, or Hawaiian/Pacific Islander.
2. All names are pseudonyms.
3. Antimiscegenation laws prohibited interracial marriage. These were state laws, and the last such laws were not overturned until the Loving v. Virginia (1967) ruling by the U.S Supreme Court.
4. Kaiser Permanent is one of the oldest and largest health maintenance organizations on the West Coast of the United States.

REFERENCES


Acknowledgement: This research was funded by a minority supplement from the NIA/NIH project “Cultural Responses to Illness in the Minority Aged” #4R37AG11144, and by grant R30-AG155272 under the Resource Centers for Minority Aging Research program by the NIA/NIH.