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Greater Inclusion of Asian Americans in Aging Research on Family Caregiving for Better Understanding of Racial Health Inequities

Aggie J. Yellow Horse, PhD[1,*] and Sarah E. Patterson, PhD[2]

[1]School of Social Transformation, Arizona State University, Tempe, Arizona, USA. [2]Population Studies Center, University of Michigan, Ann Arbor, Michigan, USA.

*Address correspondence to: Aggie J. Yellow Horse, PhD, School of Social Transformation, Arizona State University, 777 Novus, Suite 310AA, P.O. Box 874308, Tempe, AZ 85287-6403, USA. E-mail: ajnoah@asu.edu

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Abstract

With the substantial demographic changes in racial composition in the United States since 1965, research on racial health inequities must build upon the Black-White binary to assess the complex ways "race" affects health and aging. Considering variation in the prevalence and meanings of aging across racialized groups requires concerted efforts to expand and disaggregate samples. Aligned with the goals of the intersectionality framework, we argue that greater inclusion of Asian Americans is critical to advance both theoretical and methodological considerations that enable us to investigate the lived experiences of Asian Americans. Using caregiving as an example, we discuss how systemic, cultural, and interpersonal marginalization from racism and other oppressive systems intertwine with "race" to produce the race effects. Greater inclusion of Asian Americans helps further provide the opportunity to conceptualize culture as dynamic and interacting with structure to produce different racial patterns. Meaningful inclusion of Asian Americans in research requires more systemic effort to collect accurate, reliable, and quality data for Asian Americans that can be disaggregated by other important axes of stratification.

Keywords: Asian American, Caregiving, Intersectionality, Racial health inequity, Racism

With the Immigration and Nationality Act of 1965 abolishing the prohibition of immigration from Asia based on racial quota (Lee, 2019), immigration from Asia has significantly contributed to changing racial composition of the U.S. population. For instance, less than one million Asian Americans made up about 0.5% of the U.S. population in 1960 (U.S. Census Bureau, 1960); in 2019, about 21.4 million Asian Americans comprised 6.6% of the total U.S. population (U.S. Census Bureau, 2019). Since 2000, the Asian American population has been the fastest growing racialized group in the Unites States (Budiman & Ruiz, 2021). This means that understanding Asian American experiences is not only important in its own right for meaningful inclusion, but inclusion of Asian Americans in research also has significant implications for accurate and reliable assessment of the total U.S. population.

Despite changing racial composition in the United States, current aging scholarship has predominately focused on racial differences between White and Black persons, families, and populations until the late 1990s, and recently begun to include more Latinx experiences in the past two decades (Sandefur et al., 2002). However, Asian Americans remain relatively invisible in aging research due to underdeveloped theories and methodological limitations (Sandefur et al.,

2002). This is somewhat paradoxical as Asian Americans tend to have a longer life expectancy (Acciai et al., 2015). Asian Americans are also the fastest growing group among adults 65 years and older, and the only racialized group whose population growth is mainly driven by immigration (A. W. Roberts et al., 2018). For example, 87.7% of Asian American adults older than 65 years were foreign-born in 2016 compared to 13.5% of the total older adult population and 54.8% of Latinx older adults (A. W. Roberts et al., 2018)—signaling the increasing needs for not only culturally but also linguistically appropriate health interventions and resources. Moreover, as Asian Americans are the most likely to reside in multigenerational family households (Cohn & Passel, 2016), the health of older adults likely has spillover implications for other members in family households in terms of caregiving responsibilities.

To advance scholarship from merely documenting racial health inequities—the unjust and unfair distribution of health resources, outcomes, and determinants across racialized groups (Braveman & Gottlieb, 2014)—to antiracist praxis in eliminating the systemic causes, we discuss the importance of greater inclusion of Asian Americans in aging research. We use caregiving for older adults as an example. Inclusion of Asian Americans through the process of "centering in the margins" (Braveman & Gottlieb, 2014, p. 1391)—bringing in the perspectives of marginalized groups—can advance our overall understanding of social determinants of health (SDH) in the contexts of aging and race (Ford & Airhihenbuwa, 2010). Including Asian Americans can challenge the traditional theorization about the specific mechanisms generating the "race" effects (Mays et al., 2003) by interrogating (a) the effects of racial structures and their interactions with other oppressive systems, and (b) the complex interactions between structural and cultural mechanisms of SDH. This extension can substantially contribute to the scholarly momentum for the theoretical expansion to incorporate intersectionality as a framework. Greater inclusion of Asian Americans can also provide concrete methodological considerations needed for antiracist praxis for the systemic documentation of racial inequities across multiple SDH domains and implementation of research into policy (Sadana et al., 2016).

Racial Health Inequities in the Context of Aging, SDH, and Caregiving

A fundamental step in eliminating racial health inequities in aging is to identify the specific mechanisms generating the "race" effects that can be dismantled with antiracist praxis. Towards this step, the SDH framework has significantly contributed to identifying some of these mechanisms by investigating how individuals' social contexts shape health inequities through the complex interconnected mechanisms across the life span. It moves the focus of racial health inequities beyond individuals to the multidimensional and multilayered ecological settings people exist within to understand the impact of those dimensions on their health. This is a critical shift from the individualization of health framework that essentialized "race" as an intrinsic and deterministic factor in health (D. Roberts, 2011) to the critical assessment of "race" as a socially constructed fundamental cause in health inequities (Clouston & Link, 2021; Gravlee, 2009). That is, race is a proxy for social inequalities due to the individual's and group's social locations within the racialized social stratification based on "race" rather than a proxy for unmeasured biological differences (Gravlee, 2009).

To advance our argument for greater inclusion of Asian Americans for research on racial health inequities in aging, we use unpaid caregiving—the activity of providing help with various tasks or care needs (e.g., personal care, mobility help, transportation, etc.) for family or friends—as an example SDH for several reasons. First, caregiving—as a behavioral, psychological, material, and interactional process—is a key intermediary SDH (Chappell, 2016). We need more work to understand considerations of family structure and ties (Deatrick, 2017; Russell et al., 2018), and the interactions with larger structural care systems (e.g., formal health and social care systems; Chappell, 2016), especially for historically excluded and marginalized populations including Asian Americans. Omission of family contexts can also lead to serious methodological errors (e.g., omitted variables bias; Noah, 2015).

Second, caregiving is likely a key SDH for Asian Americans as they have the *highest* rate of providing caregiving (44% vs 22% for the U.S. population; National Alliance for Caregiving & AARP, 2020) and they spend longer durations of time providing care than Whites (Miyawaki, 2016). Asian Americans' caregiving may encompass a broader scope of tasks, as they are more likely than other groups to talk to doctors, help financially, and handle paperwork for older family members (National Alliance for Caregiving & AARP, 2020). In addition, qualitative work documents that Asian Americans may view caregiving differently than other groups (e.g., viewing the refusal of the caregiving responsibility as culturally unacceptable; Pharr et al., 2014).

Lastly, racial differences in caregiving have been well documented among other racialized groups in the U.S. context to interrogate the "race" effects. For instance, research has documented the variation of caregiving prevalence as well as the meanings, processes, and effects of caregiving on caregivers across racialized groups including Black and Hispanic Americans (Braveman et al., 2011; Fabius et al., 2020; Pinquart & Sörensen, 2005). However, Asian Americans remain largely absent from these large-scale studies (Pinquart & Sörensen, 2005; Schulz & Eden, 2016). In a seminal paper on racial and ethnic differences in caregiving, Pinquart and Sorensen (2005) identified two mechanisms of the "race" effects where the racial health inequities from caregiving can be generated from the "positioning" effect (i.e., differences in the mean

levels of caregiver variables) and the "patterning" effect (i.e., differences in the association of caregiver variables). The premise of the "positioning" effect of racial health inequities is that different racialized persons and groups have differing SDHs (e.g., racial discrimination in employment, education, housing etc.) due to race as consequences of systemic marginalization.

Interrogating the Positioning Effects of Race: Racial Positioning of Asian Americans and the Intersectionality Framework

Systematic reviews document the differences in the positions for both caregivers and care receivers across racialized groups (Dilworth-Anderson et al., 2002; Pinquart & Sörensen, 2005). In general, Black American, Latinx (Hispanic), and Asian American persons have a greater magnitude (severity) and width (ranges) of caregiving responsibilities than non-Hispanic White persons. Inclusion of Asian Americans provides ample opportunity to focus on investigating the "causes of the causes" in SDH research (Braveman & Gottlieb, 2014). That is, it enables us to investigate how "race" becomes defined and leveraged against particular groups based on systemic, cultural, and interpersonal marginalization from racism and other oppressive systems intertwine with "race." In other words, *what are the causes of the positioning effects of race?*

Understanding one's social location within the racialized social stratification and its effects on aging and health must be grounded in racial stratification theory. With the changing U.S. racial composition, critical race scholars have tried to address the limitations of the *biracial* paradigm (i.e., a sole focus on the Black–White binary racial hierarchy) to capture the heterogeneous experiences of non-Black people of color. New theorizations include Asian Americans and Latinx (e.g., White/non-White comparison [Skrentny, 2001] and Black/non-Black comparison [Yancey, 2003]) or with a *triracial* paradigm (e.g., Whites, "honorary whites," and "collective blacks" [Bonilla-Silva, 2004]). However, they remain inadequate to explain the racialization of Asian Americans because of the complexities of having identities at different social stratification intersections (C. J. Kim, 1999). The racial triangulation theory, on the other hand, expands the racial stratification theory by articulating that the racial positioning of Asian Americans occurs at the intersection of "racial valorization" (i.e., racial hierarchy) and "civic ostracism" (i.e., insider/foreigner) dimensions (C. J. Kim, 1999). That is, while Asian Americans may have privileges based on their supposed proximity to Whiteness on the axis of racial hierarchy, they may be simultaneously marginalized on the axis of civic ostracism through racist nativism—the system reinforcing the superiority of White "natives" over immigrants of color (Lippard, 2011).

This theoretical expansion in critical race theory is well aligned with the intersectionality framework. First proposed as an interpretive framework by Crenshaw (1989), intersectionality frames the need for the U.S. legal system to recognize the coexisting identities of Black women as Black and women to understand how Black women experience racial and gender discrimination simultaneously. This framework emphasizes how social locations within the racialized social stratification are informed by the intersection of multiple axes of advantage and disadvantage (e.g., race/ethnicity, class, gender, citizenship/immigration status, sexual identity, disability, etc.; Collins, 1990; Crenshaw, 1990; Hankivsky et al., 2010). Similarly, Asian Americans experience the "race" effect on health from their racial positioning simultaneously from both racialization and *racialized* nativism rooted in the logic of Orientalism characterizing Asian Americans as perpetually foreign via racial and xenophobic discrimination.

Interrogating the Assumptions on Inherent Cultural Differences in the Patterning Effects of Race

To date, most caregiving research focuses on the positioning effects of race, and a relatively smaller research investigates the patterning effects of race (Pinquart & Sorenson, 2005). Thus, less interrogation has focused on the question: *what are the causes of the patterning effects of race?*

A complex set of interrelated social, economic, and cultural changes influence the patterning effects of caregiving; yet there is an overreliance on cultural explanations. For example, research documents that despite a greater set of caregiving responsibilities, caregivers of color have better psychological outcomes than White caregivers, on average (Liu et al., 2020; Pinquart & Sörensen, 2005). This supposed resiliency is often attributed to "cultural differences"—such as familism—assumed to lead caregivers of color to have higher sense of purpose that potentially buffer the deleterious effects of caregiving from stress and caregiving strain.

While understanding cultural values as an added element is needed (Knight & Sayegh, 2010), overreliance on cultural explanations can be problematic as cultural explanations often assign the unexplained or unmeasured residual differences to "culture" without clear conceptualization and explicit measurement (Twigg & Martin, 2015; Viruell-Fuentes et al., 2012). Such practices can lead to false conceptualization of culture as static and unidimensional, although culture—as often imagined as identities and subjectivities—is "inherently plastic" (p. 355), changing across life span (Twigg & Martin, 2015). As nearly two in three Asian Americans are foreign-born in 2019 (U.S. Census Bureau, 2019), inclusion of Asian Americans can more critically assess the impacts of *changing* cultural influences. That is, the complex acculturative (i.e., adapting within a new cultural environment) processes of Asian Americans' experience—both how foreign-born Asian Americans acculturate over time in the United States and how cultural influences change over generations—can inform the ways

cultural explanations influence the patterning effects (Abe-Kim et al., 2001; Viruell-Fuentes et al., 2012).

Furthermore, overreliance on cultural explanations overlooks the effects of structural factors and the complex interrelation between culture and structure (Viruell-Fuentes et al., 2012). For example, while Asian Americans may have protective "cultural" factors, they also may be at greater risk of not using or having access to resources and social support due to structural, cultural, and linguistic barriers (Li, 2004; Pinquart & Sörensen, 2005). In addition, a disconnect between family member expectations of care (cultural context) and what is feasible in the U.S. context (structural context) can compound inequality for Asian Americans (Weng & Nguyen, 2011).

Inclusion of Asian Americans—in addition to inclusion of Latinx—can contribute to the decomposition of cultural and structural explanations. For example, although some work shows that Asian Americans and Latinx have similar caregiving responsibilities (i.e., positioning effects) and "cultural" values that emphasizes strong interpersonal relationships within the extended family and priority of family interests ahead of individual interests (e.g., similar patterning effects; Pharr et al., 2014), caregiving can differently affect them depending on the contexts. For instance, using the California Health Interview Survey, G. Kim and colleagues (2019) found that having a single caregiving responsibility was significantly associated with reporting worse health for Asian American and Black American caregivers, but not for White and Latinx caregivers. Despite the romanticized view on "Asian cultural values" in familism, G. Kim and colleagues (2019) found that Asian American caregivers in general were the most vulnerable group with the largest deleterious effects of caregiving on their health. Furthermore, understanding substantial within-group heterogeneity for Asian Americans can also help in teasing out the effects of structural explanations. For example, Asian Americans have the highest income inequality within group (Kochhar & Cilluffo, 2018) and likely have the greatest variance in structural barriers (e.g., access to health and social services).

Towards Antiracist Praxis on Asian American Representation in Data

Inclusion of Asian Americans in aging research on caregiving remains limited due to the underdevelopment of theory and methodology (Schulz & Eden, 2016). Asian Americans are largely omitted from the nationally representative surveys in health and aging (Holland & Palaniappan, 2012; Schulz & Eden, 2016). For example, the Health and Retirement Study (HRS) is the largest data set for investigating work, health, and aging for persons older than 50 years in the United States funded by the National Institute of Aging since its first data collection in 1992 (Fisher & Ryan, 2018). Although Asian Americans consists of 2.9% of the U.S. population 1990 (U.S. Census Bureau, 1990), Asian Americans have not been oversampled in the survey design process to ensure adequate representation to date. Of over 38,000 respondents in the HRS in 2014, 300 respondents (0.8% of the data set) are Asian Americans (Health and Retirement Survey, 2017). Such omission of Asian American data affects the ability to understand any within-group heterogeneity or disaggregate by subgroups (Schulz & Eden, 2016).

When included, Asian Americans are incorrectly assumed to be a monolithic panethnic group, which disallows critical assessments of various Asian American experiences. While Asian American as the panethnic group identity is an *achieved* self-identity based on collective struggles during the Civil Rights era (Espiritu, 1993), it also led to the false public perceptions of Asian Americans as a homogenous group (Hollinger, 2000). Because Asian Americans consist of over 20 Asian ethnic groups with different historical contexts and social locations within the racialized social stratification, such aggregation can mask significant, substantial, and meaningful differences within Asian Americans. In 2006, the HRS added new race and Hispanic-origin questions where detailed information about the subgroups within the Hispanic panethnic group can be identified (i.e., Mexican American, Puerto Rican, Cuban American, and other Hispanic origin; Health and Retirement Survey, 2017); we need similar disaggregation, possible through oversampling, for Asian Americans. These within-group breakdowns are important as social norms of familism, filial piety, and filial obligation may differ by other characteristics within the Asian American community including immigration status or socioeconomic status (Knight & Sayegh, 2010).

In discussing antiracist praxis on Asian American representation in data, we must be cognizant of systemic racism embedded in the logistics and methods we utilize in research itself (Zuberi & Bonilla-Silva, 2008). Due to data limitations for numerically small racialized populations (Korngiebel et al., 2015), critical information about Asian American experiences related to caregiving and aging often come from convenience samples or nonrepresentative samples (e.g., focusing on one ethnic group or one geographic location; Schulz & Eden, 2016). Lack of funding support and data collection hindering greater inclusion of Asian American in aging research is not new (Dong & Simon, 2018; Dong 2019). As Asian Americans are simultaneously racialized as the model minority without health needs and foreigners who are not within the scope of U.S. health priorities, Asian Americans remain invisible in public health discourse (Yellow Horse, 2021). For example, a recent study finds that between 1992 and 2018, only 0.17% of the total budget from the National Institute of Health was given to clinical research projects focused on Asian American, Native Hawaiian, and Pacific Islanders (Đoàn et al., 2019).

We assert that moving from documentation of differences to antiracist praxis to eliminate racial health inequities in

aging necessitates including Asian Americans through long-term institutional and systemic actions. Abiding commitment to systemic investment in research *about* and *with* Asian Americans is the key. Some ongoing population-based epidemiological surveys of the health and well-being of Asian Americans in a smaller geographic scale such as the Population Study of Chinese Elderly Study (data on Chinese older adults in the Greater Chicago area) is an excellent example (Dong, 2014). A relatively small but critical body of research on Asian Americans shows varying prevalence and incidence of various diseases from heart health to dementia (Gordon et al., 2019; Yoo et al., 2014) as well as family caregiving (Nugraheni & Hastings, 2021). While extrapolation—assuming overall Asian American experiences from nongeneralizable research—is problematic (Holland & Palaniappan, 2012), we must acknowledge the importance of individuals' experiences constituting a critical form of knowledge production (Collins, 1990) and push for multiple methods to center the intersectional lives of Asian Americans.

Conclusion

Greater inclusion of Asian Americans provides the opportunities from merely documenting the racial health inequities to more concrete steps in reducing and eliminating racial health inequities by investigating the "causes of the causes" (Braveman & Gottlieb, 2014) to inform policies. The need for greater inclusion of Asian Americans in aging research remains. Greater inclusion of Hispanic populations in aging research through systemic changes in data collection strategies (Ofstedal & Weir, 2011) has created momentum towards antiracist praxis. With the continuous influx of Asian immigrants and ongoing anti-Asian sentiment based on racist nativism, we urge aging researchers to finally commit to the long-term systemic changes.

We also conclude with the cautions that our argument for meaningful inclusion of Asian Americans in scholarship does not negate the importance of the Black–White binary (Brooks & Widner, 2010). Inclusion of Asian Americans and other racialized groups does not conflict with the tradition of Black scholarship focusing on White-on-Black racial problems and valuable analysis of racial structures (Brooks & Widner, 2010; Husain, 2019), and caution against the false and slippery color-blind notion of "declining significance of race" (Wilson, 2011). Rather, we assert that it advances our understanding of whether, how, and why "race" translates to health inequities in the context of aging through SDH as the consequences of racial structures and their interactions with other oppressive systems.

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Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

Author Contributions

Both authors contributed equally to this work.

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