IMMIGRANTS' ASSIMILATION AND OUTCOMES OF HEALTH: A MULTIDIMENSIONAL ANALYSIS OF SELF-ASSESSED HEALTH AMONG ASIANS AND PARAMEDICS OF ASIAN INDIAN ORIGIN IN THE U.S.

By

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ABSTRACT

IMMIGRANTS' ASSIMILATION AND OUTCOMES OF HEALTH: A MULTIDIMENSIONAL ANALYSIS OF SELF-ASSESSED HEALTH AMONG ASIANS AND PARAMEDICS OF ASIAN INDIAN ORIGIN IN THE U.S.

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Past studies have shown that among immigrant populations of color, greater assimilation into U.S. society leads to poorer health outcomes. In this context of the "immigrant health paradox," a large number of studies have focused on Latinos rather than other immigrants, such as those of Asian ancestry. This dissertation focuses on people of Asian ancestry because increasing racial and ethnic "diversity" in the U.S. demands broader understanding of health by race and ethnicity. Using theories of immigrants' selectivity, classic assimilation, belonging or distance to assimilation and discrimination, and social determinants of health, this study examines the relationship between multiple social dimensions and levels of assimilation and self-assessed health outcomes among populations of Asian ancestry. This study uses data from the National Asian American (NAA) Survey of 2008 (N=5,159), and from oral history interviews with 16 paramedics (12 nurses and 4 physical therapists; 3 men and 13 women) of Asian Indian ancestry. The data was analyzed with a mixed methods approach using Structural Equation Modeling (SEM) and Oral History Narratives within the phenomenological tradition. The SEM results indicate that there is no statistical significance between assimilation, discrimination and health outcomes. The other social determinants, however, show mixed outcomes on health. Overall, the data fits the model significantly. Further, the narratives revealed that despite their experiences with discrimination and related stress with settlement, paramedics of Asian Indian origin express fair to good health outcomes. Based on this evidence, a health paradox can be applied to racial and ethnic minorities of Asian ancestry. The findings from this study will

contribute to the understanding of social psychological and structural forces and expansion of knowledge in race and ethnic diversity and health studies, immigration study, public health scholarship.

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I dedicate this dissertation to my parents,
Mrs. Dipali Roy, Mr. Sisir Kumar Roy
and to my son, Rishav Choudhury.

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CHAPTER 1

INTRODUCTION

I felt that my voice was not heard [in my previous work place]. . . . That is why I started my own business. . . . [This was in response to a patient's complaint who said that he did not want to be treated by a Mexican]. My aide could have said to my patient that I am a human being and have right to live legally wherever I want to. . . . instead. . . . my aide said [to the patient] that I am just a little tan and not a Mexican.
- A research participant: A self-employed physical therapist of Asian Indian origin living in the U.S.

"The California Nurses Assn. has filed a class-action grievance against Sacramento-based Sutter Health and the company's California Pacific Medical Center in San Francisco, alleging that hospital managers refused to hire Filipino nurses."
Hennessy-Fiske, *Los Angeles Times*: August 19, 2010

The above quotations, one from my research participant and the other published in the *Los Angeles Times,* reflect a sense of hopelessness, powerlessness, and despair from the experiences of immigrants and racial and ethnic minorities in the U.S. Consequently, these emotions can have a strong influence on health outcomes of immigrants, as well as and racial and ethnic minorities[1]. This dissertation examines and explores the relationship between various social determinants, including assimilation and discrimination, on self-assessed health outcomes among immigrants of Asian origin living in the U.S. Additionally, this dissertation examines and explores the modifying effects of assimilation and discrimination on the relationship between socio-demographic, socioeconomic, socio-cultural, socio-political and religious attendance and self-assessed health outcomes. Based on the data obtained by oral history narratives, this study also assesses how paramedics[2] (e.g., nurses, physical therapists and other semi-skilled workers in

[1] This dissertation views race and ethnicity as separate categories rather than race as an overlapped category of ethnicity or vice versa.

[2] According to Oxford dictionary, definition of para also means subsidiary or assisting. *See* Oxford dictionaries (2014) at http://www.oxforddictionaries.com/definition/american_english/para-Hence the global definition of para-medics means staff assistants in health care industry other than physicians.

the health industry) of Asian Indian origin self-report their health trajectories from migration to settlement in the U.S.

The purpose of undertaking this research is of multiple folds. One of the major objectives is to deconstruct immigrants and race and ethnic health paradox and expand it using data from Asian Americans and Asian Indian paramedics. It is widely acknowledged that immigrants' health paradox, more broadly known as epidemiologic health paradox, is an enigma that says: relatively low education, low income and health insurance status found among Hispanic origins in the U.S. is comparable with Blacks. Regardless, health outcomes among populations of Hispanic origins are found closer to non-Hispanic whites (Markides & Coreil, 1986). Specifically, the group that produces significant positive health outcomes across Hispanics is Mexican. Public health studies that examined immigrants' health and in particular the immigrant health paradox have largely either focused on immigrants of low socioeconomic status or of Latin American origin (Abraido-Lanza, Chao, & Florez, 2005; Markides & Coreil, 1986). Likely, abundance of evidence of immigrants' health paradox and revisits are concentrated among Hispanics (*See* Camacho-Rivera, Kawachi, Bennett, & Subramanian, 2014). Consequently, at the intersection of migration, race, ethnicity and health scholarship, health and well-being data among immigrants and minorities are limited.

In relation to social class, race and ethnicity, it is well known that a low socioeconomic status poses challenges to maintaining good health. A largely prevailing low economic status among Hispanics, comparable to the economic status of African-Americans, may be one of the major reasons why health research on Hispanics is essential (Mackartney, Bishaw, & Fontenot,

2013; Markides & Coreil, 1986[3]; Markides & Eschbach, 2005). To our advantage, Hispanic health research has deepened our understanding of the epidemiological paradox and the immigrant health paradox. However, scholars have tended to equate the Hispanic health paradox with the epidemiologic and immigrant health paradoxes. It is meaningful to study health among Hispanics, however, this will solely impact our understanding of the immigrants' health paradox within one population group. Nonetheless, such understanding is likely to lead us to believe that the definition of the immigrant health paradox is and should primarily be confined to economic[4] indicators. Few studies have developed the health paradox model on the basis of social determinants[5] rather than economic characteristics. Critical understanding of the influence of social factors will decelerate if more data to capture social dynamics of immigrants' racial and ethnic health are not obtained in timely manner. Specific to health outcomes, research examining the paradox in mortality has similarly examined the data largely among Latinos (Abraido-Lanza, Chao, & Florez, 2005). The mortality paradox states that relative to non-Hispanic Whites, immigrants of Hispanic origin have lower mortality rates.

Overemphasis on the study of Hispanic data has reduced the probability of studying health and well-being among people of Asian ancestry residing in the U.S. Asian immigrants, as the second largest growing racial and ethnic minority after Latinos, demand rigorous study that

[3] *See* Markides and Coreil (1986) and Abraido-Lanza et al. (2005) for the definition of the immigrants' health paradox.

[4] Emphasis on class does not ignore overlap between social and economic factors here.

[5] In this study, social determinants should be understood as socially constructed factors that determine individuals' social condition. The social condition, in which people live, could likely be the result of social and economic gradient. The gradient effect can also be understood as spiral effect. For example, according to Marmot and Wilkinson, although in the rich countries the people of lower positions get affected more by disease than people of higher position. Contrary to this, Marmot and Wilkinson's Whitehall study finds that civil servants of lower employment grade had higher risk of most causes of death despite not living in poverty. Accordingly, social gradient of health is not confined to poverty, but it runs from top to bottom in society, with every step down the social hierarchy, less good standard of health is found that is likely to have a stronger influence of socially constructed social condition in which people live. For details on the meaning of social gradient *See* Marmot and Wilkinson 2005. "Social Determinants of Health".

will further contribute to the amelioration of the broader U.S. community. Ignoring one population over the other may decrease the diversity and inclusion scholarship and would also interfere with generalization of the research findings. Active research among Asian Americans in connection with health paradox is rare, hence pointing at data deficiency.

Some social scientists observed that mapping of cumulative living of immigrants' health suffers from an ambiguous frame of reference leading to uncertain findings in racial and ethnic health outcomes (Jasso, Massey, Rosenzweig, & Smith, 2004). Research on health and mortality paradox has significantly used the non-Hispanic White standards to evaluate the health statuses of racial and ethnic minorities. Consistent use of the non-Hispanic White frame of reference is problematic in relation to changing population dynamics. Attempts to standardize racial and ethnic health imply that, in comparison to non-Hispanic Whites, other racial and ethnic groups inherently possess a sub-minority status. Further deconstruction could mean substandardization of racial and ethnic health status is an outcome of fixed, unchangeable, biologically or genetically inherent qualities of people-of-color, which simultaneously contributes to cumulative disadvantage, and acquisition of low social status for minorities and immigrants of color[6]. This contributes to marginalization by imposing dominant White perspectives of health. Consequently, studies examining health and wellbeing among diverse racial and ethnic groups are scarce leading to limited options for substituting other racial and ethnic groups in place of non-Hispanic Whites.

[6] While in this study people-of-color are other than non-Hispanic Whites, based on the skin tone, I describe "White" as another form of color. In the social realm including living of day-to-day life, it is widely known that "White" results in invisibly accrued advantages conditioned by multiple forms of broader social constructs--historical, social, cultural, economic and political. Internalization of White hegemony by the people-of-color has consistently contributed to the understanding of Whites-as-supreme/as-protectors. The repudiation of "Whiteness" as an advantage, therefore, is a myth for the broader U.S. society, which is a challenge yet to achieve success.

Scientific studies have found that because of nativist sentiments, immigrants and racial ethnic minorities of color have consistently experienced and continue to experience discrimination in the U.S. This raises the question of whether discrimination has an adverse effect on the outcomes of health among racial and ethnic people of color and immigrants. In an effort to explain immigrants' health paradox by moving away from sole socioeconomic characteristics, this study incorporates socio-psychological, social, economic, and behavioral approaches to understanding the outcomes of health. Broadly, these factors are classified as social determinants of health that have major implications for race and ethnic minority health outcomes.

To remedy the lack of data, this study examines health outcomes among Asians that could provide a frame of reference for measuring health by race and ethnicity. The lack of data on health outcomes among Asians precludes them from being used as a baseline. Additionally, studies have rarely probed the advantages that go with being non-Hispanic White, when the group is used as a baseline to measure the health of other races and ethnicities (Jones,Truman, Elam-Evans, Jones, & Jones, et al., 2013). To gain more understanding in migration, race and ethnic health, this study forwards a case for examining the influence of social determinants on the outcomes of health among Asians to rectify existing data dearth problem. .

The overview of theory and method used in this study are as follows: This study primarily uses the theory of assimilation. Theoretically and methodologically, studies examining assimilation and health have mainly focused on immigrants' acculturation into behavioral or cultural patterns, such as the food, exercise, smoking and drinking habits of the host societies. Social belonging and social distance, as indicators of assimilation have rarely been used as tools for understanding self-assessed health. In addition to investigating cultural or behavioral

patterns, this study extends on previous research by primarily focusing on features of social belonging and social distance. The implication of assimilation assessed broadly as the dynamic formation of various social determinants that overlaps with social belonging and social distance has rarely been used to understand self-assessed health. This study uses and defines assimilation, implications of social belonging and social distance based on multiple theoretical strands that are elaborated under various relevant sections. They will be followed in the later parts of the dissertation. The concepts of social belonging and social distance, used in this study, are mainly borrowed from social psychological and socio political standings. Considering assimilation as a social process, hence a likely embodiment of phenomenology or phenomenon, the primacy of assimilation in this study holds the theoretical underpinning, and is developed using Chicago school's classical theory of assimilation.

Empirical evidence suggests that assimilation, belonging and distance all have linkages with health (Berry, Kim, Minde, & Mok,1987; Berry, Kim, Power, Young, & Bujaki, 1989); Williams & Sternthal, 2010). From the prism of social psychology, social belonging and social distance this study taps into the phenomenological study of individual-environment interaction with individuals as the unit of analysis. The phenomenological tradition is embraced as part of the qualitative study in this dissertation that will be detailed under the methods section. Although the impact of the Civil Rights Movement led to the decline of racial and ethnic discrimination, the evidence of marginalization, alienation and isolation indicates that it continues to exist in more subtle forms (Bonilla-Silva, 2006; Feagin & O'Brien, 2003). Therefore, the incorporation of multidimensional and multilevel approaches to examine health outcomes based on the dynamics of individual-environment interaction is more complementary and comprehensive in relation to study characteristics.

This study focuses on self-assessed health data gathered from paramedics/ health care professionals by utilizing memory driven or oral history interviews. Self-assessed health has been widely used in immigrant, race and ethnic health literature. Sociological research focused on race and ethnicity has rarely examined data on self-defined health conditions. Health data gathered from paramedics and health care professionals would generate data accuracy because of their professional ability to carefully and systematically assess health. In addition, data collected using oral history method since the time of their entry in the U.S. is an attempt to obtain long term assessment of health based on memory driven data.

Recent methodological studies show that use of mixed, quantitative and qualitative research, methods enhance the explanatory power of the data. For example, Thaler (2012) finds that mixed methods "enable us to tie the broader pattern revealed by quantitative analysis to underlying processes and causal mechanisms that qualitative research is better able to illuminate [when] examining the interactions of structure and agency" (Thaler, 2012, p.xxx). This study uses a mixed methods approach. According to Greene, Caracelli, and Graham (1989), mixed methods research is defined as "those that include at least one quantitative method (designed to collect numbers) and one qualitative method (designed to collect words) where neither type of method is inherently linked to any particular inquiry paradigm. Creswell, Klassen, PlanoClark, and Smith (2011, p.8) list multiple reasons when a research problem is suitable for using mixed methods: 1. When a data source is insufficient. 2. Results need to be explained. 3. Exploratory findings need to be generalized. 4. A second method is needed to enhance a primary method. 5. A theoretical stance needs to be employed. 6. An overall research objective can be best addressed with multiple phases or projects. In this study the purpose of using the mixed methods approach is to explicate the interaction between individual and environment based on

immigrants' individual experiences after coming in contact with race relations in the U.S. Intermixing of methodological processes trace the pathway to extending the findings from numeric to in-depth stories. As crucial as it is to study health care paramedics (e.g., nurses, therapists, paramedics etc.), using one method over the other (qualitative vs. quantitative) would leave study of this population incomprehensive. According to the dyadic relationship that is flowing through two methodological processes, qualitative enquiry can fulfill an in-depth understanding of the mechanisms involved in the processes of importation and meaningful integration of immigrant workers in the U.S. In this domain starting from their overall migration experience to speaking about their health, the qualitative elaboration has shed light into some of the new emerging patterns of immigrants' health trajectories. This emerging new pattern would have been compromised in my research if I had used one method over the other thereby limiting the opportunity to ground the study in theory. Methodological limitation (use of either quantitative or qualitative) would have compromised the generalization or theoretical grounding. In light of these much needed objectives in this study, each reason that has been listed by Creswell et al., (2011) above provides a valid contribution in explicating the rationale behind the use of mixed methods. The use of mixed methods validates epistemological strands (Greene et al., 1989) and provides triangulation, complementarity, development, initiation, and expansion of the findings. The typologies are further elaborated in depth in Chapter 4.

For this study the sampling strategy is based upon a combination of multiple layers. Some of the sampling strategies used are: selective, snowball and purposive. Respondents chosen for the oral history interviews were processed with purposive, snowball and selective sampling strategies. Flyers were distributed in clinical and hospital settings from where samples of paramedics of Asian Indian origin were randomly selected. Simultaneously, the researcher is an

insider of the Asian Indian population. The researcher used her insider and other forms of ethnic capital (details are in Chapter 3) to gain entry into the research site. The researcher is a Classical Indian singer who was honored to sing *Bhajans* (devotional songs) at different celebrations in the temple. By singing at the celebrations in the temple researcher was able to come close to the community. This supported to overcome *gate-keeping* and *gate-keepers* in the temple[7]. The researcher located one semi-skilled professional from the temple association and appointed one respondent as a point person to gain access to numerous others – a strategy implied in snowball sampling. This study selected only those individuals who had migrated after 1960, a period of contemporary globalization leading to mass migration from Asia. Due to traditional gendered socialization pattern, service workers who responded to be interviewed were mostly female. Literature has documented the rise in female labor migration and scholars have defined the pattern as the feminization of migration (Sassen, 2009)[8].

The Context: The U.S.

This study focuses in the context of the U.S. The reason behind selecting U.S. as the context is that in U.S. history the prominence of race relations was critical. In addition, the influence of past scientific explanations, e.g., Eugenics, of racial hierarchy greatly influenced both popular and scholarly beliefs about racial hierarchy that continue to pervade U.S. fabric differentially over time (Bonilla-Silva, 2006). The burgeoning racial and ethnic diversity in the

[7] This study is not an ethnographic research. The terms gate-keeper and gate-keeping pertains to the Sociological use only.

[8] Sassen (2009) illustrates that the internationalization is highly concentrated among the top and the bottom levels of labor supplies and occupational distribution. In the middle, labor characteristic is temporary and non-globalized. Sassen, however, does not reflect adequately on the nature of duration associated with labor type in the upper and lower levels. Following feminization of labor, Sassen describes female labor migration is diverse in characteristic. The form of women migration out of which society gains maximum revenue is concerned with economic globalization (Sassen, 2009, p.187).

U.S. today has also given rise to newer forms of racial conflicts as the consequences of the September 11, 2001 (9/11) incident illustrates (Ewing, 2008; *for details see* Marger, 2006, p. 5). Yet, of all traditional immigrant receiving nations, currently U.S. ranks highest in socio-cultural and socio-demographic heterogeneity (Marger, 2006). Although Canada and several traditional European nations have been often paralleled with the U.S. in immigrant receiving context, scholars claim that U.S. is still undergoing an experimentation phase; hence, this unsaturated condition for the U.S. provides valid reasons to gather more data or updating of the previous data.

The context and the immigrants' settlement patterns

The context of immigrants' settlement and their adjustment, in relation to assimilation in the U.S. milieu remains the center of debate. While multiculturalism or pluralism has been legalized in nation-states, such as Canada, Netherlands and Australia, the U.S. is yet to undertake a breakthrough from assimilation in addressing growing population dynamic. For large numbers of Southern and Eastern European emigrants who entered the U.S. prior to the 1960s, Sociologists, viewed assimilation (integration) as an inevitable process in their settlement in the U.S. (Alba & Nee, 1997; Gordon, 1964; Portes & Rumbaut, 2001). Not all immigrants, however, are seen as embracing the classical theorization of assimilation (Alba & Nee, 2009; Berry, Kim, Power, Young, & Bujaki, 1989; Castles, Miller & Ammandola, 2009) in the current scenario in traditional immigrant receiving nations. Classic assimilation implies shedding off ethnic distinctions (Gordon, 1964). According to Gordon, the American experience could display three central tendencies: Anglo Conformity, the melting pot, cultural pluralism. The Anglo conformity theory demands the complete shedding of the immigrant's culture of origin in favor of the values and behavior of an Anglo-Saxon core. The Melting pot indicates biological merger,

intermarriage or blending of immigrants into the culture of the host society to form a new one. Cultural pluralism is defined as the preservation of the ethno-culture including involvement in the activity types of the host. In addition, Gordon emphasized a systematic process, an overall development of subsequent stages in attainment of assimilation as zero sum outcomes. The major stages are: 1. Cultural or behavioral (language, religion, values etc.).

2. Structural assimilation (educational participation, political participation, intermingling with mainstream population at large.
3. Large scale intermarriage or amalgamation.
4. Identification.
5. Attitude reception (absence of prejudice).
6. Civic Assimilation (absence of value and power).

A primary reason for non-assimilation of immigrants in the U.S. is the structural stratification and differentiation by race, ethnicity, gender, religion, economy, and social and cultural backgrounds; often, the intersection of two or more factors play a dominant role in determining assimilation. The structural response of the traditional U.S. society typically follows a reductionist approach by putting up barriers to multiculturalism and pluralism for immigrants and minorities of color. Yet increase in minorities of color receives, therefore, no well developed theory conducive to understanding the phenomenon of population diversity and its impact on health outcomes.

A U.S. centric study is more relevant because of the nation's foundation grounded in capitalist economy and labor migration. Historically, the U.S. has depended on importation of labor migrants for its development. In the contemporary U.S., demand for laborers in various economic sectors has not subsided. These labor needs are primarily fulfilled by the emigrants

looking for better opportunities. The racialized experiences of immigrant laborers in the U.S. are not an uncommon finding in migration studies. In addition to this, experiences of poor treatment of racial and ethnic minorities are not an uncommon knowledge.

This study focuses on the high skilled labor migration of Asian Indians and paramedics of Asian Indian origin. Since the passage of the Hart-Celler Law of the 1960s and with the contemporary broader political and economic changes brought about by the neoliberal policy of the U.S., the migration pattern shifted from massive entry of Europeans to non-Europeans into the U.S. The neoliberal policies led to what is often generally referred to as globalization. This is not just an economic phenomenon, but flow of capital, goods and trades are accompanied by the flow of ideas, identities, cultures, and people (Castles, Miller, & Ammandola, 2009). The traditional immigrant-receiving western countries, where contemporary globalization has brought a massive number of immigrants of color, have developed their own strategies to regulate newcomers. The recent large number of immigrants' entries from the global south is changing the racial and ethnic composition of the U.S. fabric in magnitude and direction. The primary sending regions constitute Asia, South America, the Caribbean, and Africa. In an increasingly multiethnic and multicultural society such as that of the U.S., it is of immense importance to address the growing diversity highlighting social change and development. At this crucial juncture of growing racial and ethnic diversity, to serve communal harmony in traditional host nations that carry the burden of overt to covert forms of racial and ethnic disparity (Bonilla-Silva, 2006), public debate has revived on the issues of immigrants' integration (Marger, 2006). This study acknowledges and addresses the issues surrounding immigrants' integration. At the same time this study connects between immigrants' integration and health.

Rationale for studying health of immigrants

Studies predict that international migration in the U.S. cannot be abated in the near future (Marger, 2006). Also, despite improvement in the overall outcomes of health, race and ethnic health disparity continues to unfold. Political and legal milieu has imposed restrictions and increased the sense of vulnerability among immigrants that is likely to have negative consequences on health. For instance, often times immigrants fail to comprehend the complexities of immigration laws. In the case of U.S. legal entries, according to Immigration and Nationality Act section 212, all "aliens" are subject to medical exam due to inadmissible public health concerns (U.S. Citizenship and Immigration Services, 2015). This policy reflects a xenophobic attitude toward immigrants. Inherent in these laws are a perception of insecurity and alienation that are likely causes of internalization of insecurity leading to social distance among immigrants at the onset of their entry in the U.S. Such policies lead up to fear of being diagnosed with serious health concerns and resulting deportation. Consequently, immigrants and minorities of color visit hospitals less frequently, which in turn perpetuate health disparity between immigrants/ people of color and natives. Simultaneously, such processes lead to more number of emergency visits increasing the burden on taxpayers' money on such health care costs.

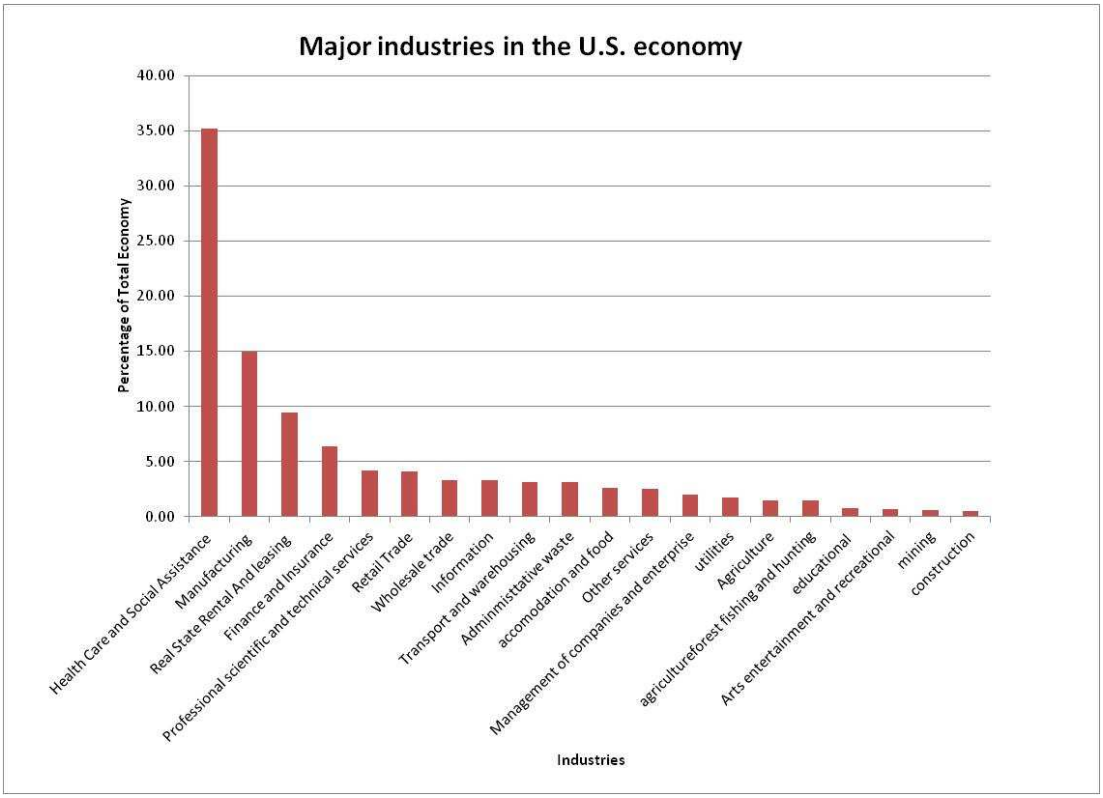
In the light of current political context during 2013 and 2014, two major public policies acquired mass attention: 1. immigration overhaul, and 2. Affordable Health Care Act. Although these two controversial policies although have been passed through the GOP with consensus, yet they are contested. Affordable Health Care Act or Obamacare went into effect in 2013 and in the same year the Obama administration addressed immigration overhaul emphasizing increasing the number of visas for STEM workers, including high skilled professionals. Skilled migration is an important resource for governments seeking to build their country's human-capital base and

make the most of global trade and investment opportunities (Sumption, Papademetriou, & Flamm, 2013). These two recent changes in public policies have major implications for broader society in the U.S. because U.S. is witnessing major transition in its racial and ethnic composition. Since 1960, multiculturalism and multiethnic social characteristics are replacing the primary Black and White division in the U.S. Traditional immigrant-receiving western nation-states, such as the U.S. are now challenged with social, political, cultural and economic integration of the new immigrants as they continue to live racial and ethnic minority life over time. Public and scholarly discourse focuses on the degree that new immigrants or racial ethnic minorities are going to be absorbed by the broader U.S. society (LaVeist, 2013). In other words, social scientists are continuously striving to understand how or by what process different racial and ethnic groups integrate. While integration is an important and complex institutional shift that requires immense understanding, simultaneously, this demographic transition is leading to the formation of a multiracial and multicultural hierarchy where deeper understanding of health issues by race and ethnicity are yet to be understood beyond the Black/White paradigm.

Although U.S. health care has achieved significant improvement in the health of its people, as racial and ethnic minorities are growing it would be important to obtain an in depth understanding of racial and ethnic minority health. This would be a reflection of healthy statistics, patterns, and processes of health and wellbeing in the U.S (Interactive tools — measure of America: A program of the social science research council, 2016). Moreover, both, as part of the social and moral responsibility and as an added advantage, the U.S. government should promote and protect healthy outcomes among its skilled immigrants as contributive to the nations human capital base. As historical evidence indicates, America has been an immigrant-labor dependent nation since its inception, and this ultimately resulted in building a powerful

nation-state. Following the dominant form of economy today, where financial transactions and labor recruitments have become increasingly global and integrated in the open market system, building and maintaining a strong human capital base is critical to the growth of global trade opportunities. At the national level, efficient means to translate opportunities into success can be found by optimizing the nation's human-capital base; this, however, means strategic implementation of effective plans for strengthening minority workers. In-depth understanding of health outcomes among racial ethnic minorities and people of color is critical as racial health disparity continues to experience unequal outcomes between minority and non-Hispanic whites. Differential treatment constitutes a major cause of outcomes in health disparities. The percentage contribution of health care economy over other industries justifies the study of health care laborers as the research subjects (**FIGURE 1**). In addition to this, a majority of the studies on immigrants' destination focused on traditional immigrant ports of entries, such as California and New York. This, however, is changing and new immigrant "gateways" have formed since 2000 (National Asian American Survey, 2008; Ramakrishnan, Junn, Lee, & Wong , 2008; Singer, 2004).

FIGURE 1: Major industries in the U.S. economy



Note: The source data for **FIGURE1** is obtained from American Hospital Association. The graph is produced by the researcher

Study population

This study focuses on immigrants and minorities from Asia and Asian origin who are naturalized or by birth citizens and entered the U.S. in the later years. According to the U.S. Bureau of Census (2012), the population measure of Asians as compared to the Europeans is recorded as: Europeans: 7.3 Million or 74.5% of total population in 1960 vs.4.9 Million or 12.1% of total population in 2011; Asians 0.5 Million or 5.0% of total population in 1960 vs. 28.6% of total population in 2011. In this study, data from paramedics such as nurses, physical therapists and other semi-skilled health care professionals of Asian Indian origin has been used. Studying this population is significant because the percentage of health care professionals, especially

nurses, in the Asian Indian community increased since 1970s due to the increased demand for health care professionals in the health care industry.

Rationale for the selection of the study subjects: Asian Americans and paramedics of Asian Indian origin

Current data shows that Asians are the second largest minority group in the U.S (United States Census Bureau, 2012) after Latinos. In addition, during the peak days of the economic boom from 1980-90, data on labor migration depicts a massive flow of skilled laborers from Asia. Contrary to the expectation, the National Origin Quota Act brought in immigrants *en masse* from Asia and only a limited number from Europe during the 1960s. Given the contemporary demographic shift which indicates that Asians are growing, it is especially crucial for immigrant scholars to continue to study this group.

Both racial and ethnic, as well as health and migration studies, note that until the 1950s racial issues were discussed largely in terms of Blacks and Whites. As we entered in the 21st Century, racial and ethnic composition diversified in the U.S. (Lillie-Blanton & LaVeist, 2013; Foner & Fredrickson, 2004; United States. Census Bureau, 2012). Although this demographic diversification leads to an increase in research among Latinos, a focus on Asians is rare.

As with any social process, a shift in the demographic pattern entails social, economic, cultural and institutional dynamics that press for continued scholarly attention to changing social experiences with this demographic transformation. Among Asian Americans, the Chinese were the first to gain entry into the U.S. during the period of liberalization and also the first to experience discriminatory law, the Chinese Exclusion Act of 1882 and later Asian Exclusion Law of 1924. Due to their statuses as colonies, India under the British and the Philippines under the U.S., both Filipinos and Indians were treated as aliens. Despite the eventual abolition of the

Asian Exclusion Act in 1952, entry of Asians into the U.S. was permitted only on the basis of racial quota, rather than on national origins (U.S. Department of State, 2010).

Considering the socio-historical, contemporary political economy, and demographic context in the U.S, Asians, are certainly an important group to study. For example, evidence from a recent study (Fox & Jones, 2013) claims that, Asians and Caribbeans are the primary subgroups that have experienced acute social marginalization compared to other subgroups who have emigrated to the U.S. The stereotype against Asians emphasize that they are "model minorities." This equally contributes to the lack of health research among various Asian groups. The "model minority" perception has shaped the public notion that Asians are well off socioeconomically, therefore requiring little research. In a democratic society, one of the basic responsibilities of the citizens is to eliminate factors that are potential contributors to social inequality.

Understanding Asians' experiences by the hyphenated identity as Asian American over simplifies the experiential distinctness, and loses the variability if any within the group. Nonetheless, when speaking of Asians, the popular perception is overwhelmingly focused on Chinese experiences. Asians' experiences in the U.S. are not primarily or significantly reflected and duplicated by Chinese experiences as popularly assumed. The Chinese Exclusion Act of the 1880s is another responsible factor to legitimize and to emphasize atrocities towards Asians as indicative of only a Chinese problem; rarely are the experiences of other Asian origins given exclusive importance. This notion, that the experiences of one Asian group can be duplicated for all Asians, portrays a reductionist approach and leads to ignorance of prejudice and exclusionary behavior towards Asians other than Chinese. Therefore, this study is an attempt towards an in-

depth study of the influence of social determinants on health for one group of Asian origin: Asian Indians.

According to historical data, Asians were laborers in the gold rush, rail road construction, agricultural sector and served in the military during World War II. In this study, I also chose to study paramedics of Asian Indian origin residing in the U.S. According to the global definition, paramedics are nurses, physical therapists, technicians and other semi-skilled health care workers. There are multiple reasons for choosing paramedics of Asian Indian origin. In relation to labor importation, contemporary globalization has brought large scale semi- to high-skilled migration from the global south[9], and Asian Indian nurses and therapists have been used to fulfill labor shortage in the U.S. health industry. For instance, current predictions on health care labor statistics show that during the past fifty years the U.S. has continuously imported semi-skilled service workers (nurses and physical therapists) to fulfill the shortages of registered nurses and physical therapists in its health care system. An estimation projected by The U.S. Department of Health and Human Services (HHS) indicates that the U.S. experienced a shortfall of 111,000 service workers (Registered Nurses and Physical Therapists) in health industries in 2000. This figure is predicted to grow to 275,000 by 2010 and expected to triple reaching 800,000 Full-Time Equivalent (FTE) by 2020 (Brush, Sochalski, & Berger, 2004).

Fulfilling the labor need within hierarchical standing of skills, importation of workers from English speaking countries such as India was seen as practical, especially considering historical colonial linkages with English speaking colonies (e.g., U.K for India and U.S. for the Philippines); an example of a colonial/English language linkage with a geographic region

[9]The term "global south" is commonly used by the United Nations, and stands for the countries included in the Southern hemisphere of the world. *See* the report titled "Cooperation, traditional and new, critical to sustainable development, UN officials stress," http://www.un.org/News/dh/pdf/english/2014/21052014.pdf.

influencing labor importation is the state of Kerala in India[10]. Although health industry depicts a sharp rise in demand for both semi-skilled workers and physicians, this study selects nurses over physicians. Within the institutional hierarchy of health care, physicians hold substantially powerful positions in comparison with paramedics (as the definition suggests semi-skilled professionals qualify as medics of para level in comparison with physicians who are only medics excluding para). Given both the historical and contemporary backgrounds of Asians' presence in the U.S., addressing their migration and health experiences will contribute to migration and health as well as to race and ethnic scholarships.

Concluding remarks

Overall, globalization, socio-history, demographic, country-specific skills, English language ability, and shortages in health care laborers are some of the characteristics that play important roles in considering Asian Americans and Asian Indian paramedics as important populations for this study. Asian Indian paramedics are also chosen for obtaining accurate self-assessed health outcome data. The selection of Asian Indian paramedics in this study contributes to trustworthiness of the data. According to Brush, Sochalski, & Berger, (2004) recruitment and employment of semi-skilled service workers in the U.S. health industries are not a new phenomenon, but what is different from the past is the organized form of recruitment of nurses,

[10] Kerala sent a significant number (0.21% of India's total nursing stock in 2001) of nurses abroad as compared to other states in India since 1970s-80s (Hawkes et al., 2009). The reason that such a large number of nurses emigrated from Kerala could be tied to the colonial history of the region, its high literacy rates, and progressive education programs for preparing nurses located in this state. The early entry of Christian missionaries in Kerala (Hoefer, 2001) is another significant historical and cultural reason for producing so many nurses there; due to their enhanced access to service giving organizational networks, and lower levels of stigma associated with service work, later periods saw institutionalization of service work in different job sectors including health care. A remarkable book which illustrates the migration of nurses from Kerala is by Sheba George; more concepts description from George's book relevant to this study are discussed in the notes in Chapter 5, qualitative findings.

physical therapists and technicians. The following section briefly describes the organization of the dissertation chapters.

Organization of the dissertation

Chapter 2 reviews immigrant and health literature. This chapter bridges and integrates migration, international immigration, race and ethnicity and public health literature to provide a theoretical background of the model developed for the quantitative and qualitative methods. Chapter 3 describes quantitative, qualitative approaches used in this study. The rationale for using a mixed methods approach is also discussed in this chapter. Furthermore, recruitment process, sampling strategy, and data analysis are also part of this chapter. Chapter 4 focuses on the findings from quantitative data analysis. Chapter 5 indicates results from qualitative data analysis. Chapter 6 elaborates discussion, conclusions and data limitations.

CHAPTER 2

THEORY AND LITERATURE

Introduction

This chapter sheds light on the scholarship of existing research on health and self-assessed health outcomes among immigrants, racial and ethnic minorities. More specifically, the review will focus on health outcomes among Asians and immigrants of Asian Indian origin while assessing the multidimensional linkages between health outcomes and key social factors. The key social factors used in this study, and reviewed here, are: Religious attendance, socialization pattern, civic engagement, financial status, and education characteristics and socio-demographic measures including self-described health, race, ethnicity, and ancestry. Theories of assimilation and discrimination are used as prism to understand the relationship between the selected social factors and self-assessed outcomes of health.

The chapter starts with a brief history of international migration followed by a section on Asian Indian immigration into the U.S. The immigration pattern begins since the pre-colonial era that played an important role in the formation of the majority and minority race and ethnic relations in the U.S. The review on assimilation focuses on how theories of assimilation were developed to explain differences between majority and minority relations. According to the theory of assimilation there is a strong association between assimilation and various forms of social determinants proclaiming assimilation as a much complicated paradigm than simply assuming its significant association and interchangeability with duration of stay or overtime stay of the immigrants in the U.S. For example, the central tenets in classic assimilation thesis show that it is tied to attitude, structure and culture among others. Remaining sections use and examine

different social determinants that are broadly categorized as social psychological, socioeconomic, socio cultural and socio political.

Migration and formation of the racial and ethnic transformations and relations in the U.S.: A brief history

This section focuses on how the presence of major immigrant waves and racial and ethnic groups changed the demographic constituent and racial and ethnic formations in the land that later came to be known as the U.S. (*See* Barr, 2008; Gallagher, 2011; Hirschman, 2004; Zinn, 1999). During the pre-colonial era, the entry of Europeans, importation of enslaved Africans by the European slave owners, and exclusion of Indian natives increasingly set the stage for a Black/non-White minority and White majority divide. This institutionalized a minority and majority race and ethnic relations (Farley, 2011; Gallagher, 2011; Perea, 1998; Gold, 2004; Perea & Slater, 1999[11]; Yetman & Steele, 1975; Zinn, 1999; Wu, 2003)[12]. The minority and majority relations were reasonably sustained by the development of the eugenics movement in the mid-1800s that further led to the dominance of White supremacy (For details on Eugenics movement *See* Engs, 2005; Hirschman, 2004; Rosen, 2004[13]; for details on White supremacy see

[11] See Perea and Slater 1999 for binary in cultural context. Generally understood, ethnicity is measured as a substitute to culture. See Mary Waters (1999) as well for a general definition of race and ethnicity.

[12] The dominant/classic race paradigm of Black and White faced challenges and criticisms as of in recent Race and Ethnic scholarship (See, Gold, 2004; Perea, 1998).

[13] As notes Rosen (2004), in 1883 British scientist Francis Galton coined the term "Eugenics." Although initially religion and Eugenics may have seemed at odds with each other, a close look will reveal that there is much more overlap between religion and the eugenics movement than as initially assumed. According to Francis Dalton, Eugenics should be understood as a new religion (as cited in Rosen, 2004). Francis Dalton's goals in Eugenics were no less haughty and evangelical in vision than fanatic Christian ministers' (as cited in Rosen, 2004). Borrowed from Greek, Eugenic means "good in birth." A supporter of natural selection, Dalton illustrated that Eugenics promises reproduction of better and the fittest specimens of humanity. Eugenics rooted in the U.S. soil for three spanning decades from the 1910s to the 1930s. It is to note that Dalton's use of Eugenics as cited in Rosen (2004) not only leaves "good breed" to the extent of natural selection, it extends the idea of Eugenics to connect with human behavior when reference is made to "humanity" (p.5). Connection such as this between "humanity" and Eugenics goes beyond simplistic maintenance of genetic superiority to embrace "humanness or tolerant behavior" as the other meaning of "humanity" implies. Specifically, the meaning of the term "humanity" also means tolerance, benevolence or humanness, suggesting behavioral connotations as in humanity. The paradoxical relationship

Rodriguez, 2011)[14]. A review of immigration history in the U.S. notes that "prior to 1820, few federal documents were kept about how many arrived and remained" (Barkan, 2013, p.xiii). Based on available data on the largest populations, out of the total population in the new land by the 1870s, were noted as:

> Canadians, the Chinese, the Danish, the French, Germans, Dutch, Swedish, Irish Catholics, Irish Protestants, the Jews, Mexicans, Norwegians, Poles, Spaniards, the Swedes, and the other British (Welsh, Scots, English), and Africans (Barkan, 2013, p. 3-4).

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between Eugenicists' basic principles and implications lying underneath the meaning of "humanity" is important to According to Rodriguez (2011) the foundational formation of White supremacy is multiple global circuits and historical determinants of trauma, fatality, and social disruption that is embedded in present-day social forms under which we currently live (p.45). White Supremacy is not just an ideology; it is a social construction that is internally complex and historically dynamic. The historicity of White supremacy behaves similar to centripetal force that keeps a moving object in a radial proximity to an identifiable center along a circular path. The orbital flow of the object keeps it moving with a constant speed and equal distance from the center, the location of the centripetal force, unless an external force, such as gravitational pull or friction, acts against centripetal to move the object away in its own momentum (Rodriguez, 2011). In this sense, the white supremacy's excessive violences to keep up with its massive ambitions of "Manifest Destiny, democracy or the making of white modernity is a consistent flow around the orbit to accomplish projects in process, which are white supremacy's social substructure (p.51). By developing this connection between physics/centripetal force and white supremacy, Rodriguez captures the internal complexity of white supremacy that carries immense capacity to maintain a never-departing sort of constant speed to fulfill its goal of mushrooming supremacy. Although race as an ideology emerged during different times independent of European colonial powers, race as an ideology has also been established in sociology (for a brief overview see Marger, 2011; Fredrickson, 1982). note here.

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The new migrant settler groups by the 1870s along "with the extensive population of Africans – set the stage for the accommodation and acceptance of some populations (Barkan, 2013, p.3-4; Wright, 2013). At the same time, Native Americans who were already present, experienced confrontation, threat, and challenges brought in by the new European settlers that included disease, and other issues with health and overall living patterns.

Increasingly from the 1870s and during later periods, history depicted the conquest and expansion of the European powers in the land that later became the U.S. This eventually turned it into "White America," where "racially mixed, religiously different, and [those who were] culturally and economically at odds with White American patterns" (Barkan, 2013) were deemed as "others." Since then, it is commonly believed that the "whitening" of America initiated WASP (White, Anglo-Saxon, Protestant) culture, which gradually started to deepen its roots in American society. The relationship between the White majority and minorities of color in the U.S. set the stage for the development of various patterns of social interactions. Additionally, ensuring the submission of minorities to WASP acculturation and eventual assimilation was the primary goal of mainstream Americans. To this end, socio-legal processes were also developed with the politicized intention of increasing the number of European Whites as majority (Lee, 2004)[15], that in turn used to continue White supremacy (*See* Bonilla-Silva, 2006). For example, the presence of racial ideologies have been viewed as propagating social actions conducive to fostering racism that furthers racial structures (Bonilla-Silva, 1997; Bonilla-Silva, 2006). In

[15] The historian Erika Lee divides the twentieth century American immigration into three periods:
1. Open Immigration of 1880s to 1920s, when 22 million entered the U.S. 2. Restriction Period: from 1920s to 1960s. 3. Liberalization period: from post 1965 era— 27 million entered the country. The notable argument here is that although the 1965 immigration law was deemed as a radical step toward immigration reform, however, several of the restrictive racial features of the immigration restriction period repeated. The terms such as "gatekeeping" became part of the immigration law during late twentieth century and reemergence of "gatekeeping" intensified once again with the 9/11 incident resulting in admitting only favorable immigrants who are deemed assimilable into the Anglo-Saxon core.

historical structural practices, the passing of the Chinese Exclusion Act in 1882 and the enactment of the Family Reunification Act were framed with the intent to maximize the numerical entry of Europeans into the U.S. However, the uprisings of the Civil Rights Movements indirectly resulted in the abolition of the Quota Act (the National Origins system) of 1920s[16].

The 1940s, and later decades, were instrumental in shaping the racial and ethnic transformation of the social fabric of the U.S. After the 1940s, precisely by the end of the World War II, international migration into the U.S. was increasingly of minorities of color. The aftermath of subsequent wars and civil unrests, e.g., Civil War, World War I, World War II and civil wars in Hungary, Soviet Union, Yugoslavia, much of Central America, Iraq, Afghanistan, Southeast Asia, Middle East, and South America led to emigration to (for refugees) and entry of new immigrant groups into the U.S. (Bankston III, 2006; Barkan, 2013; Padolsky, 2006). The entry of diverse groups of immigrants in the U.S. was additionally facilitated by the reforms of American immigration laws initiated in the 1950s and continued with the Immigration and Nationality Act of 1965; the Refugee Act of 1980; the Immigration and Control Act of 1986; the Immigration Act of 1990; and additional Immigration Acts in 1996 and 2001. In sum, unlike the mass migration from Europe (Foner, 2000) largely until the 1940s, later migrations, both voluntary and involuntary, are noted more profoundly as the entry of diverse racial and ethnic groups, with minimal commonality of culture and tradition with early Europeans; they now continue to be in large numbers from Asia, the Caribbean, and Central America (Dinnerstein, Nichols , & Riemers, 2003; Dinnerstein, Nichols, & Riemers, 1990; Dinnerstein & Riemers,

[16] See The 1965 Immigration Act: Asian-Nation: Asian American History, Demographics, & Issues (2001). Retrieved April 20, 2016, from http://www.asian-nation.org/1965-immigration-act.shtml for more details.

1999). Although the immigrants from these nations are numerically increasing, the social, political and economic power continues to lie within the dominant Whites (Feagin & O'Brien, 2003).[17] In traditional American society anyone who differed from dominant Whites or WASP Americans were regarded as Blacks or possessors of impure blood or simply non-equivalent to human beings. In the majority-minority race and ethnic relations pertaining to unequal distribution of power, the Black and White division stands out as most important and crucial because only African Americans were and could easily be victimized as slaves compared to other minority groups[18]. This venomous social treatment formed the baseline of race relations in constructing the Black and White model of racial hierarchy. Nevertheless, the effects of pseudo-scientific findings rendered firmness to the idea that genetic inferiority lies among Blacks or people of color and Whites naturally belong to a superior race (Hirschman, 2004)[19]. All of these factors combined together create the inertness of the Black and White divide in which the White maintain superiority and hence continue to form the basis of comparison for other color lines.

In the immigration history of the U.S., two major immigration waves are noteworthy: between 1880 to 1920 and 1965 to present due to their distinguishable characteristics (Barkan, 2013). Unlike the coming of "huddled masses" between 1880 and 1920, primarily from Europe

[17] This literature review is predominantly focused on the accumulation of minority and majority stratified relations that continue to exist between Whites and non-Whites even after the civil rights movement. This literature review on the historical pattern of racial and ethnic formation is not meant to provide the changing nature of race and ethnicity in details in the U.S. over time. More specifically, this literature review does not touch base with how several immigrant groups from Europe who entered into the U.S. were initially rejected as "White." Additionally, this literature will not focus on details of the civil rights movement and its impact over other minorities.

[18] During the pre-colonial era, neither the indentured servants imported from Europe nor the Indians native to the Americas could be enslaved (For a brief overview of this interesting argument, *see* Farley, 2011). Indians were native to the land, hence possessed collective resources to fight outsiders. Indentures of British origin could not be enslaved as any report of malicious treatment of these laborers would stop Britain from sending further workers to the U.S. farm owners, meaning loosing farm labor (For more conceptual details on similar form of race relations see Fredrickson, 1982).

[19] This idea was also incorporated in the Eugenics movement.

(Foner, 2002), from 1965 onwards a large proportion of immigrants constituted of highly-skilled and goal oriented people from the global south. This was a result of the abolition of the Quota Act and implementation of skill-based visas under the Immigration and Nationality Acts of 1960s and 1990s. Additionally this reversed the historical pattern of race and ethnic entry into the U.S. significantly of non-Hispanic Whites of European origin to people of color from other places. Despite the overall change in racial and ethnic migration pattern the heavy reliance on laborers has stayed the same since the practice of slavery. Before the 1965, the laborers who arrived in the U.S. were mostly unskilled or manual workers. This, however, changed as contemporary labor demand in the U.S. arose for both high-skilled and low-skilled immigrants (Sassen, 2001). The initiation of migration from the global south diversified the social, economic, and cultural fabric of the U.S. The perpetuation of further migration led to the rise of contemporary globalization (Cross & Moore, 2002)[20].

Prior to contemporary globalization, the significant difference of descendants of African slaves from European migrants led to the division of the society into dominant Black and White divide. At this time the understanding of the racial and ethnic mentality in the U.S. was a biracial construct consisting of Black and White (*see* Feagin & O'Brien, 2003). As the labor demand and immigration laws changed, more immigrant groups entered the U.S. Consequently, the racial and ethnic transformations from a biracial to multiracial structure unfolded. Nevertheless, the mentality of the people held on to the simplified biracial divide, such as, Black and White, White and non-White etc. This biracial divide was problematic because of several reasons. For

[20] According to Cross and Moore (2002), contemporary globalization was initiated in the post-cold war era. The significant characteristic of contemporary globalization is highlighted as triumphant capitalism featuring economic basis of transnational connections. Furthermore, unlike nineteenth century globalization, contemporary globalization is understood as less overtly based on direct military invasion (*See* Cross &Moore, 2002 for more details on contemporary globalization).

example, while White identification continued to held on to the power, “people of color” were lumped into the “inferior” group. In this way, starting from the time of slavery, Whites have been able to incur their interest at the expense of labor exploitation, discrimination, segregation, isolation and marginalization. With Whites in power, minorities increasingly start to accept their lower position in racial and ethnic hierarchy. This causes minorities to experience a lowered self-esteem because of the internalization of their inferior status (Karlsen & Nazroo, 2002; Porter &Washington, 1993; *see* Smith, 2010). With lower self esteem it is more likely for the minorities to allow themselves to be exploited, discriminated, segregated, isolated and marginalized by the majority. Once the hierarchy pattern is created, it continues to replicate in a vicious cycle (Bonilla-Silva, 1999; Feagin, 2001; Sidanius & Paratto, 1999, 2004; Song, 2003). Until today, the power of Whiteness that resonates with WASP ethos dominates not only within the boundaries of the U.S., but instead crosses the borders of nation-state. The rise of contemporary globalization is primarily a phenomenon that took shape because of political economy and capitalization of periphery by core nations.

The high skilled workers were enticed to come into the U.S. for better socioeconomic opportunities because in the U.S. there is an increased demand for minority workers to fill jobs that Whites reject. The combined effects of contested bureaucratic power and demand-pull factors such as manpower, human capital, and demographic decline, have sent mixed messages to immigrants of migrant export nations (Hollified, Martin, & Orrenius, 2014). These structural characteristics are often regarded to overcoming the hurdles of undertaking immigration and labor market adjustments. Simultaneously, these characteristics motivate the prospective migrants to take the challenges of international migration. However, when the high skilled workers arrive following the deceptive advertisements, they experience devaluation of return on

their skills of origin and are placed into jobs that require a lower skill set (Reitz, 2001)[21]. This results in high skilled minority workers to be underpaid, which forces them to live in poor social and economic conditions. The workers residing in these social and economic conditions begin to compare themselves with socio and economically advanced Whites. This triggers a culture of assimilation towards becoming like "Whites." Assimilation, the hierarchy pattern, and contemporary globalization serve as a catalyst in this process of maintaining the un-equilibrium of power on many different levels.

Influence of global structural changes on racial and ethnic transformations in the U.S.

Macro, meso and micro levels are theorized as building blocks of migration as a process (*see* Massey, Arango, Hugo, Kouaouci, & Pellegrino, 1999) rather than an event. The macro level transformations associated with contemporary globalization are marked by political and economic changes. These determinants led to the initiation of a new form of immigrants' entry leading to rapid socio demographic diversification since the 1960s in the U.S. The stark contrast between the current immigration waves coming from Asia, the Caribbean, Africa and Latin America are of remarkable importance in noting their relationship with race and ethnic relations. For example, Foner (2002) notes that regardless of antipathetic views directed towards eastern and southern Europeans after their arrival, gradually their experiences turned into glorifying of their past. Their successes are celebrated with strong empathy. On the contrary, images of the "new" arrivals since the 1960s and later are depicted as "alien others," who are more likely to experience trouble fitting into the mainstream U.S. fabric.

[21] Reitz (2001) makes some important comments about underutilization of skills among immigrants in Canadian society. According to Reitz, the barriers to successful immigrants' integration are non-recognition of immigrants' credentials, skills and work experience by various institutions. While Rietz's findings are focused on the Canadian context, these findings apply broadly to traditional immigrant-receiving nations including the U.S.

Since the 1960s, streams of skilled immigrants are entering into the U.S. (Barkan, 2013; Foner, 2000). In the context of the political economy, the impact of the 1960s Bretton Woods Agreement opened international borders to free markets (Castles & Miller, 2009b; Chase-Dunn, 2013; Guhathakurta, Jacobson, & DelSordi, 2007). This translated to wiping away debts of developing countries in exchange for allowing the entry of U.S. businesses across their borders. However the developing countries needed to provide the laborers, who were severely underpaid and poorly treated, while the capitalist U.S. continued to make profits. The emergence of minority professionals in low-income jobs, such as working in assembly lines and sweatshops, provided evidence of the poor working conditions, harsh treatment, and institutional racism in the U.S. and across the globe. These social processes have an immense effect on immigrant and minority health outcomes.

While governmental control of core nations such as the U.S. over the peripheries in the early phases of globalization was marked by giving foreign aid through the international credit agencies, more direct control in a transnational labor economic system was initiated "through private investment by transnational corporations which directly own and control the process of production" (Chase-Dunn, 1975, p.721). Although the entry of markets into the developing nations was initiated with the neoliberal ideology of providing freedom and well-being to people and governments of "peripheral nations" (Harvey, 2005), it led to the formation and reinforcement of American hegemony. This provided monopolistic power to the American multinational companies and more direct control over the peripheries, which was more indirect when peripheries depended on foreign aids given by international credit agencies (Chase-Dunn ,1975, p. 3). Corporations supersede the power of nation-states when they act across borders leading to more flexibility in employing low wage workers from developing countries (Sassen,

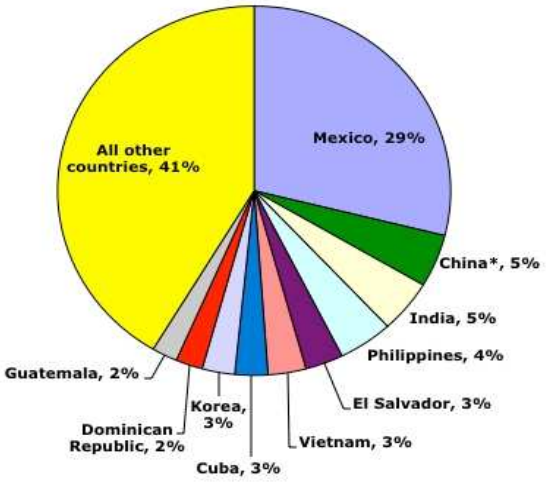
1999). Furthermore, the entry of the companies into the developing nations allowed easier access to bringing in more immigrants to fill jobs in the U.S. Consequently, this intensified immigrant entry as pre-employed company workers began to enter the U.S.

According to Yuval-Davis, Asian migration due to trading networks in America goes back to 1400s (Parker 2010;Yuval-Davis, 2006). Although the periods prior to 1930s, in the U.S. immigration history, witnessed "momentous changes in migration from global" perspective (Barkan, 2013), however, the period starting around the 1940s and later saw breathtaking differences in the type of immigrants entering globally than any previous eras. In 1965 leading Asian countries in immigration were Philippines, China, and India. Regardless, "in 1965 the U.S. government passed the Hart-Celler Law which brought reform to the controversial Mc-Carran Walter Act that restricted immigration from Asia to only 2990 per year" (Lyon, 2013). Overall, implementation of the Hart-Celler Law in 1965 set limits to immigration to 170,000 from the Eastern and Western Hemispheres. The large number of Asians first arrived from Japan and China (Saran, 1985). After World War II, the incarceration of the Japanese in the U.S., as well as the post war economic boom in Japan, led to the decrease of the Japanese entry into the U.S. China, during World War II, suddenly became aligned with the U.S., as it was fighting against Japan. As a result, Chinese migration increased which mostly constituted of professionals and students (together China and Japan constituted the largest portion of the total Asian immigrants in the U.S.). As for other Asians, in 1960, only 12,000 Indian immigrants were living in the U.S., accounting for 4.7 percent out of the total of the 41.3 million foreign-born populations (Zong & Batalova, 2015).

A recent data show that among all top immigrant sending countries in the U.S., India is the third largest country of origin for sending immigrants from Asia (**FIGURE 2**), after Mexico

and China. The proportion of Indian immigrants among all foreign-born migrants grew from less than 0.5 % in 1960 to close to 5% in 2011 (Whatley & Batalova, 2013). A recently released report on Indian immigrants in the U.S. shows that since the 1990s Indians have become the second largest immigrant group in the country after Mexicans (Sahay, 2009) and have surpassed those who are born in China, the Philippines and Vietnam (Zong & Batalova, 2015).

FIGURE 2: Top sending countries by the percentage share of Asian and Asian Indian immigrants among total immigrant populations in the U.S., 2009



Source: Batalova and Terrazas (2010)

The presence of Indian immigrants' in the U.S goes back to 1820 (Barkan, 2013). According to Zong and Batalova (2015), similar to early Chinese and Japanese immigrants, preferred Indian immigrants in the U.S. were farmers; they were mostly settled in California and hired as agriculture workers. Although early Asian Indians were few and referred to as "Hindus," in the official documents, a majority who first came into the U.S. were Sikh-Punjabis (Poros, 2013). The restrictive Immigration Acts of 1924, the Johnson-Reed Act, which effectively banned immigration from Asia, stopped further immigration from India ('The Immigration Act of 1924/the Johnson-Reed act–1921–1936 - Milestones - Office of the Historian', n.d.).

Since the 1960s there have been several factors that contributed to an increase in the entry of Asian Indians into the U.S. The 1965 Immigration and Nationality Act, and later the Immigration Act of 1990, accelerated the entry of skilled-immigrants from India (Sahay, 2009; Saran, 1985). From 1980 to 2013 immigrants of Indian origin increased ten-fold, from 206,000 to 2.04 million, roughly doubling every decade (Zong & Batalova, 2015, *See* **FIGURE 3** in the following sections). Additionally, Asian Indians were preferred by Americans over other Asians because of their physiological and language similarities with American Anglo Whites. However, the early experiences of Asian Indians in agricultural and other job sectors are marked by "intersecting forces of colonialism and anti-colonialism, racism, and capitalism as they struggled to become part of American society" (Poros, 2013, p.209). After the Indian independence, the India's dream to construct a free India on the basis of technology and western science led to involve the U.S. in its active development. Indian assimilation history has a complicated trajectory in the U.S. Although many Indians thought of themselves as whites or Caucasians during the1980s, the structural racial complexities of discrimination never allowed them to be seen as such by Americans. For example, among incidents of racialization and discrimination,

Thind vs. Supreme Court is of notable importance. Labor immigration remained an integral part of the socioeconomic development of the U.S. society since the colonial era (Dinnerstein, Nichols, & Reimers, 2003; *also see* Hirschman, 2004; Heines & Sutch, 2006) and varies across racial and ethnic groups.

Contemporary labor migration of Asian Indians: High and semi-skilled immigration

Primarily, two types of labor immigrants have been given entry into the U.S.: industrial workers and skilled and semi-skilled professionals (Batalova, 2011). Whereas early immigration into the U.S was following discrimination against national origin quota, later immigration policies allowed skill-based entries. Consequently, since 1965 a large number of semi-to-high skilled immigrants from India entered the U.S (Sahay, 2009). Due to the diplomatic relationship between the U.S and India after World War II, commonly held interests in economic liberalization and supporting of democracy resulted in shaping favorable policies on the part of both the U.S. and India to allow entry of skilled immigrants from India which has increased sharply ever since 1965 (Sahay, 2009). Data show that in the fiscal year 2014, Indian citizens received the most temporary high-skilled worker H1B visas (there is only one visa category, H1-B, which is also used for semi-skilled health professionals, such as nurses and therapists hierarchically situated below doctors in the socioeconomic gradient (Batalova, 2011), accounting for 70 % of the total 316,000 petitions for starting and continuing employment as endorsed by the U.S. Citizenship and Immigration Services, USCIS) (Zong & Batalova, 2015). According to Zong & Batalova (2015), India is the second-largest sending country for international students to the U.S. after China: in the 2013-14 school year, roughly 103,000 Indian-born students were enrolled in U.S. higher educational institutions. Similarly, to explicate the importance of the study of the impacts of assimilation on health outcomes among paramedics of Asian Indian

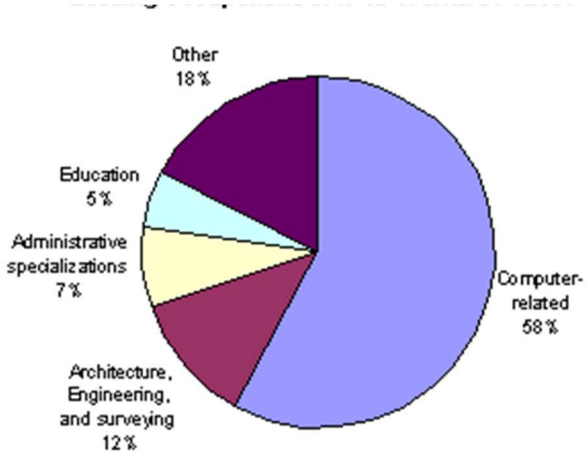
origin, the latest data show that in 2012 half of all Indian immigrants granted legal permanent residence (LPR) were admitted through employment-based preferences in comparison with 48 percent of immigration based on family relationships among 66 percent of LPR overall (Jachimowicz & Meyers, 2002[22]; Whatley & Batalova, 2013).

Although it is estimated that by 2050 there will be more numbers of labor importation toward high-skill end in professional and business sector including industrial technology rather than health care support (Gelatt, Batalova, & Lowell, 2006; Grieco, 2004), other evidence shows that the health care industry contributes the greatest amount of production to the total economy when compared to other major industries, including industrial technology (*See* **FIGURE 1**) making health care labor and health study crucial topics to explore further and especially within the health care industry (Goldin, 2001). Nonetheless, increasing aging population in the U.S. is a consistent driver of job growth in health care industry and home health care ('Employment projections: 2014-24 summary', 2015; Henderson, 2012). This population transition could potentially lead to high labor migration in health care industry.

In sum, although labor migration has played an important role in various social contexts, entry of skills, exclusive of labor, have proliferated the context of social and economic intersection. It is, however, needless to say that preference for skilled rather than family based entries enabling diversification of migration is a structural formation resulting in infiltration of "desirable" over "undesirable" among Asians.

[22] See Jachimowicz Maia and Deborah Waller Meyers. (2002)."Temporary High-Skilled Migration" Migration Information Source. Available from http://www.migrationpolicy.org/article/temporary-high-skilled-migrationfor details on importation of temporary high skill migration since 1952 in the U.S. Also, high-skilled *workers* refer to any individual admitted on the basis of professional education, skills, equivalent experience, and/or specialized knowledge in a given field.

FIGURE 3: Workers on (H-1B) by leading occupations: Fiscal year 2001



Source: Immigration and Naturalization Service, (July, 2002).

Selective migration and its relationship with health outcomes

Despite the fact that a large number of immigrants from Asia in general and India in particular are entering into the U.S. as skill-based immigrants, however, as assessed by critical demographers, the numerical increase among minorities is least likely to effect the relationship disequilibrium that exists among concentrated Whites and people of color in power (Horton, 1999). The notable paradox is that regardless of the increase in number of people of color, the power will stay stable and inculcate cumulatively among Whites. Based on the contemporary migration pattern, data from Asia indicates that immigration is positively selected (Foner, 2000). In addition, immigration is positively selected on multifarious dimensions such as age, gender and health. In the context of immigrants' health, much writing (Turra & Elo, 2008; Hummer, Powers, Pullum, Gossman, & Frisbie, 2007; Abraído-Lanza, Dohrenwend, Bruce, Ng-Mak, & Turner, 1999) has documented that individuals who migrate are relatively healthy compared to those who stay (Jasso et al., 2004). Despite the fact that the global share of international

migration has remained stable at only 3% over the past several decades (Vargas-Silva, 2014), it has not ceased to be selective. Scholars who study immigrants' health have widely noted that selectivity of migration should be considered seriously when assessing for health outcomes (Jasso et al., 2004) because there is a strong association between socioeconomic status and health outcomes at the first entry, which in itself is a cyclic process towards immigrants' assimilation.

Classical and new assimilation

In the U.S. entry of different racial and ethnic minorities and their coming into contact with the majority population necessitated understanding social patterns of interactions across racial and ethnic groups. Moving away from biological factors explaining human life and living, the entry of social sciences developed understanding of human life as socially constructed. Darwin's theory of selectivity was shared by social Darwinism (*See* Hirschman, 2004) explaining for racial and ethnic variations and interactions. Equally important was the development of assimilation theory in understanding race and ethnic relations equally adopted by public health scholars to explain for of health among immigrants, racial and ethnic groups (Abraido-Lanza, Armbrister, Flórez, & Aguirre, 2006); this will be discussed in a later section.

Classical assimilation was theorized as unilinear (Gordon, 1964), and indicated that immigrants, racial and ethnic minorities of color eventually "become White." Since the Chicago School's development of this unilinear classic assimilation, revisionists also indicated that eventually immigrants assimilate into American society (Glazer, 1993; Alba & Nee 1997; Brubaker, 2001; Bean & Stevens, 2003). As an alternative to classic assimilation, the trajectories of "new assimilation" were constructed (*see* Alba & Nee, 1997). In classic assimilation the central tenets constituted certain stages or aspects of the assimilation process: cultural or

behavioral (language, religion, values), structural assimilation (educational participation, political participation, intermingling with mainstream population) at large, large scale intermarriage or amalgamation (intermarriage between two gene-pools representing different population), identification assimilation (developing a sense of people-hood that is based exclusively on the host society), attitude reception assimilation (absence of prejudice), and civic assimilation (absence of value and power). The different stages of assimilation in Gordon's (1964) model proclaimed closeness to English-speaking White Protestants that made up and yet are the majority of the U.S. population. As noted, evidence from Europeans' experiences show that assimilation generally occurs within three to four generations, but sociologist Sharon L. Sassler's (Cited in Brown & Bean, 2006) work on European immigrants to the United States has shown that educational attainment even among third-generation Irish and Germans lagged well behind that of native-born Whites whose ancestors were living in the country for more than three generations (Brown &Bean, 2006). Indeed, groups may vary in their rate and attainment of assimilation for a number of reasons, including the level of human capital (education) they bring with them and the social and economic structure of the society that they enter. Based on these constraints assimilation can be "bumpy" (Gans, 1992), selective (Alba &Nee, 1997), subjective (Waters, 1999) or fuzzy/ blurry (Brown & Bean, 2006) at the end. In addition, depending on the dynamics of racial and ethnic diversity, meaningful assimilation may be defined as "integration" (Berry, 1997) in a multicultural society. Depending upon the type and extent of assimilation endured, racial and ethnic minorities are likely to experience disparity/diversity in health outcomes.

Immigrants' health and the context of self-rated health

More than 100 years ago, the health of immigrants posed one of the most pressing problems in the United States. Consequently, in response to the fear of communicable diseases, since 1887 health clinics were set up to examine immigrants' health status and screen immigrants suspected of bringing disease into the country (Evans & Baldwin, 1997). The Marine Hospital Service Facilities that later came to be known as the National Institutes of Health was set up to select healthy immigrants (Evans & Baldwin, 1997), which were elaborately real and frightening experiences administered by the public health physicians to size-up immigrants up to the objectified standards of "good health" (Markel & Stern, 2002). Furthermore, to draw the critical and political lines along race and class, immigrants were divided between "new" and "old" stocks. In early 20th century these "old" stocks were immigrants from northern European (e.g., Great Britain, Ireland, Scotland, Belgium, Denmark, France, Germany, the Netherlands, Sweden, Norway, and Switzerland) countries (Markel & Stern, 1997) and were upheld as the standard for health mark-up. The "new" stock during this time comprised immigrants who originated from eastern, central and southern Europe. A large proportion of "new" immigrants who entered were mostly destitute and low-skilled. In addition to class indicators, "evolutionary doctrines" of racial inferiority of "new" immigrants labeled as "swarthy," "presilent," or of "bad stock (Higham, 1988; Kraut, 1994) were grounded in "science," to legitimize the genetic inferiority as "definitive" answer to their un-assimilable and unhealthy characteristics (Markel & Stern, 1997). Labels such as these are constructed ways to scapegoat "new" immigrants from the WASP acculturated "old" stock. Nonetheless, these stereotypes are centered upon immigrants' health conditions as troublesome; when in reality immigrants brought miniscule levels of

sickness. As the past evidence would show, immigrants were mostly victims of harrowing oceanic-traversing conditions because of which they experienced illness.

Evidently, as this discussion notes, the exclusion of early 20th century immigrants were situated along the class and race lines. As health based exclusions were prevalent among immigrants from Europe in the 20th century, it is therefore no surprise that exclusion and discrimination on the basis of health commonly practiced for immigrants of color including Asians and Latin Americans. However several other factors in determining immigration changed since the passage of the Hart-Celler Law, which provided impetus to family reunification and skill-based immigration (Zolberg, 2008). In the past, most immigrants arrived by ship; however, this mode of transportation was replaced by air rides. Technology has also given rise to developed medical treatments across the globe. The eradication of communicable diseases and the decline in the mortality rate has led to a rise in population in many countries. This, in turn, resulted in crowding and competition for limited resources in developing countries that were already burdened by huge debts. These conditions resulted in the rise of potential emigrants whose goal was to infiltrate U.S. society. While immigration in the U.S. multiplied mostly due to the entry of Asians, Latin Americans and Caribbeans, unlike the entry of significant numbers of uneducated immigrants, at the turn of the twentieth century, now both skilled and unskilled laborers entered the U.S. Seemingly, the visible color component became nativists' objections making judgments on health conditions of these immigrants more severe.

An interesting observation related to the study of immigration and health relates to the comprehensiveness and complementary processes that emanate from incorporating the perspective of health into migration studies. According to Jeffery Evans, the Director of the National Institute of Health and Baldwin (1987), the incorporation of the perspective of health

into the study of migration renders dynamics to the field of migration studies because health is in consistent condition of change. More specifically, According to Evans &Baldwin (1987) the dynamic characteristic of people's movement as a process rather than a discrete event is additively stimulated when the interaction effect of migration and health is taken into account. A similar study by Jeffery Evans (1987) indicates that while research on migration is often obscured by interactions between population parameters, incorporating health into migration research accelerates the dynamics of a social process that is likely to be lost if migration and health are assumed as discreet events; more precisely, if health is considered unchangeable and inert biology.

The relationship between migration and health as a process embodies dynamism that is subject to repeated change over time. Accounting for the future growth of the American population, immigration continues to rank as a strong driving force (Heisler & Shrestha, 2011). Continuous flows and the resulting demographic shifts have given rise to scholarly and policy interests in immigration and health. Nevertheless, the relationship between immigration and health outcomes draws greater interest now than ever before because of the greater number of people of color entering the country. It is often argued that health issues among Asians are negligible due to their entry and their occupying high socioeconomic positions in the society. The attainment of high socioeconomic status has rendered model minority status among Asians indicating lack of data on Asian diversity leading to inconsistencies in outcomes of health among Asians (Frisbie et al., 2001).

By using the National Health Interview Survey of eight major Asian groups—Chinese, Filipino, Asian Indian, Japanese, Korean, Vietnamese, Pacific Islander, and Other Asians in the U.S. Frisbie et al. (2001) found that while overall Asians and Pacific Islanders reported their

health status as either similar or sometimes superior to Whites, Asian Indians showed an 8% higher rate of falling ill enough to take sick days compared to other Asian sub-groups in the study. The overall self-reported health outcome findings, however, are consistent with most of the results of previous studies on racial, ethnic and immigrant health in the U.S. (Frisbie et al., 2001). In addition to this, a longer duration of stay in the U.S. showed a negative impact on self-assessed health outcomes (Singh & Siahpush, 2002). The duration of stay in the study accounted for assimilation extent among immigrants. Focusing on self-assessed health by race and ethnicity including sub-groups, such as Asian Indians, some findings illustrate that compared to stayers, the tendency towards practicing preventive health among Asian Indians ranks higher in the U.S. (Saran, 1985). Structurally, the privatization of the health care in the U.S. indirectly promotes and integrates the shortage of preventive health measures. As such, the perception of practicing preventive methods to positive health among racial and ethnic groups is important to understanding the disparity in health.

Although, in the past, health was defined as human's capacity to adapt to the environment (Dubos, 1959), it has recently been defined as a multidimensional—social, physical, psychological, cultural, biosocial and multilevel—individual, community/neighborhood and global process (Barr, 2008). Generally, health-related behaviors are defined as acceptable individual actions resulting in either positive or negative health outcomes, such as higher rates of illnesses, death, or the absence of such unhealthy symptoms (Barr, 2008). The sociological interpretation of health-related behaviors has been understood as the linkages between individual choices and socio-cultural determinants. For example, while dietary habits could be a personal choice, which could also depend on the cultural dietary practices that an individual follows

(Landale & Orporesa, 2001). Outcomes of health can vary among Asians by culture, behavior, economy including various other social measures.

Wu and colleagues (2006) found that among Filipinos and Asian Indians women have higher levels of perception of barriers to mammogram screening when compared to other Asian groups included in the study. Levels of income had an inconsistent influence on perception barriers among Chinese and Asian Indian women. While Chinese women were five times more likely than other Asian groups to have perception barriers to mammogram screening, Asian Indian women were eight times higher (Wu, West, Chen, & Hergert,2006). Based on these findings, health care education is still essential among Asians and Asian Indians despite the fact that they are often thought of as a model minority or "honorary Whites" in tri-racial grouping because of their socioeconomic status and high median income (Bonilla-Silva, 2006). A few studies (Gee, Spencer, Chen, & Takeuchi, 2007; Gee & Ponce, 2010) on public health have studied the effects of discrimination on health outcomes by cause-specific health outcomes among Asians in the U.S. Similarly, although rare, a recent study (Inman, Tummala-Narra, Kaduvettoor-Davidson, Alvarez, & Yeh, 2015) in counseling psychology on social determinants of health attempts to study the effects of discrimination on mental health outcomes among Asian Indians in the U.S. As indicated because of their stereotypical "model minority" status, it is often presumed that Asians and Asian Indians do not experience discrimination. In addition, the findings of this study show that discrimination exists and is real among Asian subgroups and has influence over health outcomes. The specific health outcomes tested were cardiovascular, respiratory and pain related health problems. While largely discrimination is a significant predictor of cardiovascular problems, more specifically everyday discrimination is strongly

related with disaggregated chronic conditions[23] (Gee et al., 2007). While Chinese, Filipino, Vietnamese were selected to study among all Asians included in the sample, Asian Indian, Japanese and other Asian subgroups were lumped together as a category. In sum, the study discusses some data on Asian Indians' health outcomes ranging from self-reported health to mental health outcomes. As it is clear that Asian immigrants' data in general and Asian Indians' data on health in particular is rare (Frisbie, Cho, & Hummer, 2001), it is timely that more studies are carried out to amplify the data dearth. Furthermore, lumping of Asians into Asian American/ Pacific Islanders creates "semblance of homogeneity" among this diverse group causing misleading and inaccurate findings on health (Fuller-Thomson, Brennenstuhl, & Hurd, 2011).

Self-assessed health

A recent research shows that association of self-assessed health and mortality has been well established in the literature (Jylhä, 2009). According to Jylhä (2009), self-rated or self-assessed health "an individual and subjective conception that is related to the strongest biological indicator, death, constitutes a cross-road between the social world and psychological experiences on the one hand, and the biological world, on the other" (Jylhä, 2009: p.308). The studies that focus on the theoretical development of self-assessed health argue that instead of drawing from statistical assessment of self-assessed health, the concept should view self-assessed health as a process. Although there are variations in how self-assessed health questions are constructed, this study primarily takes into account global measure of self-assessed health. This simple question measuring health outcomes started to be used in sociological research since the 1950s (Garrity,

[23] The cause-specific illnesses included in the study are: Cardiovascular (Heart attack, stroke, heart disease, high blood pressure); respiratory (hay fever, asthma, tuberculosis, and other chronic lung diseases including emphysema, and pulmonary); pain (chronic back or neck etc.); other (diabetes, HIV/AIDS, cancer, epilepsy); for more details see (Gee et al., 2007; p.1276).

Somes, & Marx, 1978; Maddox, 1962; Suchman, Phillips, & Streib, 1958). In other disciplines, self-assessed health measure gained popularity when it was used in the context of mortality (Singer, Garfinkel, Cohen, & Srole ,1976; Mossey & Shapiro, 1982; Kaplan & Camacho, 1983; Crossley & Kennedy, 2002; Jürges, 2007). As noted by Jylhä (2009), some evidence was also found using self-assessed health in clinical studies for disease risk screening (May, Lawlor, Brindle, Patel, & Ebrahim, 2006) and clinical trials (Fayers & Sprangers, 2002). After the Edward A. Suchman, Bernard S. Phillips and Gordon F. Streib study in 1958, describing self-assessed health as a subjective measure opposed to objective measure, self-assessed health was used most notably by Ellen Idler focusing on its role in mortality (Idler, 1979; Idler & Benyamini, 1997; Idler & Kasl, 1991; Idler, Leventhal, McLaughlin, & Leventhal, 2004). These studies provide evidence of the wide influence of self-rated health and its role in measuring mortality. The studies such as this support the use of self-assessed health that my study use, and attribute self-assessed health to both objective and subjective measures.

Migration and health study: Influence of social and cultural factors

Although scholarship on immigrants' health has increased over the past two decades, gradual importance is increasingly given to the rarity of social determinants use in health care research by scholars and health care professionals equally recently (Anderson, Fullilove, Scrimshaw, Fielding, & Norman, 1999). Insights from a recent analysis on immigrant health indicate that research on immigrants' health lacks integration across disciplines (Acevedo-Garcia, Sanchez-Vaznaugh, Viruell-Fuentes, & Almeida, 2012). Increasingly, public health concerns have moved away from the innate biological determinants of health to identifying the social dynamics of immigrant health (Jasso et al., 2004). Understanding immigrants' health from arrival to settlement in the new location plays an important role in comprehending the social

determinants of racial and ethnic health (Berkman & Glass, 2000; Williams & Sternthal, 2010; Goodman, 2013; Lillie-Blanton & LaVeist, 2013). However, focusing on health and well-being and emphasizing why and how social processes such as assimilation, discrimination, socialization religious attendance, and civic engagement influence the public, immigrants', and race and ethnic health (Link & Phelan, 1995; Berkman & Glass, 2000; Jasso et al., 2004) has yet to develop more in sociology. For example, cultural and behavioral explanations have been provided for a major finding in immigrants' health outcome, also called immigrants' health paradox. Immigrants' health paradox states that Hispanics experience better health and lower adult mortality rates than African Americans and non-Hispanic Whites (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999). Similarly, in migration and health literature the other persistent finding states that the health of immigrants seems to deteriorate with their duration of stay in the United States (Cohen, 2004, p. 8). Multiple explanations have been presented supporting these two recurring findings. They include: 1. migrants' cultures of origin promotes more favorable behavioral profiles in relation to diet, smoking, and alcohol consumption; 2. migrants' cultures of origin support more cohesive social networks and social support mechanisms; 3. migrants are more likely to be healthier because of positive health selection that facilitates migration; and 4. migrants are healthier because of positive selection of migration for health (Jasso, Massey, Rosenzweig & Smith, 2004).

Immigrants' selectivity and duration of stay: Determinants of outcomes of health

Both migration studies literature and scholarship on health disparities note that the process of immigrant selection has played an important role in reproducing immigrants' levels of health over time (Palloni & Ewbank, 2004; Jasso, Massey, Rosenzweig, & Smith, 2004). Historical evidence shows that in the U.S., immigrants' entry, dating from the days of Ellis

Island, has in large part depended on the selection of healthy migrants. Based on the gains and costs models of contemporary migration theories (Bakewell, 2008; Jasso et al., 2004; Taylor, Arango, Hugo, Kouaouci, &Massey et al., 1996), studies show that those who migrate tend to be healthier compared to those who stay at home (Jasso, Massey, Rosenzweig, & Smith,2004). Moreover, evidence based on remittance sent to the origins clearly shows that migration of healthy individuals incurs greater return on monetary gain. However, the bulk of the migration is represented by low-skilled immigration, which is gradually changing since 1995 (Fix, Papademetriou, Batalova, & Terrazas et al., 2009).

Interestingly, however, some scientific studies on acculturation find that health conditions among immigrants deteriorate with a longer duration of stay in the U.S. (e.g. Abraido-Lanza et al., 2005; Cho, Frisbie, Hummer, & Rogers. 2004; Landale, Oropesa, Llanes, & Gorman , 1999). For example, studies done by Abraido-Lanza and colleagues (2005), Cho and colleagues (2004), and Landale and colleagues (1999), among many others, argue that Latinos represent the most interesting case in evaluating health outcomes among immigrants due to their health paradox. This argument, which engages with the protective effects of culture, norms, family support, and dietary habits within the Latino families, contends that the influence of these factors is a catalyst to positive health outcomes. However, even among Latinos, with a longer duration of stay health condition deteriorates, but is usually found to be less deteriorated than that of the native-born (Akresh, 2007; Cho et al., 2004). According to Akresh (2007) a longer duration of stay in the U.S., compounded with increased knowledge of English and acculturated health behaviors, directly or indirectly, leads to poor health outcomes for Hispanics.

Provided that the category of “Hispanic” is marked as “ethnic” to collect census data on race and ethnicity, and that “Hispanic” does not differentiate between different races (Barr,

2008), this could clearly mean that the Hispanic health paradox can potentially be applied to Blacks, Whites, Asians, and other immigrant racial groups in the U.S. Nonetheless, by examining race and ethnic selectivity, research has also found inconsistent health outcomes within Hispanics as a group. For instance, studies show that whereas foreign-born Hispanics, specifically Cubans and Mexicans, are more likely to experience this Hispanic health paradox, Puerto Ricans are the least likely to experience it (Hummer, Powers, Pullum, Gossman, & Frisbie, 2007; Cho et al., 2004; Abraido-Lanza et al.,1999).

Migration and health study: Influence of socio-economic and socio-demographic factors

Since Michael Marmot's groundbreaking Whitehall study of British civil servants, socioeconomic influences on health have been widely acknowledged (Marmot, Rose, Shipley, & Hamilton, 1978; Marmot, Adelstein, Robinson, & Rose, 1978; Marmot, Stansfeld, Patel, North, & Head, et al., 1991; Marmot, 1998; 2006). However, the role of socioeconomic status in determining outcomes of health in general (Marmot, 2006) and specific to immigrants' or racial and ethnic minorities' outcomes is complex (Seeman, Merkin, Crimmins, Koretz, & Charette, et al., 2008)[24]. Studies have found some health problems are more likely to occur among economically better off individuals or populations, and socioeconomic status is sensitive to a few health conditions (Crimmins, 2005; Crimmins, Soldo, Ki Kim, & Alley, 2005).

Although the study (Marmot, Fuhrer, Ettner, Marks, & Bumpass et al., 1998), indicates the significant effects of poverty (which is a widely accepted indicator of socioeconomic status) on health and infant mortality, the findings surpass overall simplistic influence of poverty to

[24] In their analyses of NHANES III, a nationally representative sample of the US, Seeman and colleagues (2008) find influence of education and income gradients in biological risks. The gradients were seen for each of the individual biomarkers comprising our index of biological risk, along with consistent gradients for each of the subscales reflecting major systems of biological activity such as inflammation, metabolism and cardiovascular activity.

explain for the pathways that poverty as a socioeconomic condition uses to influence health outcomes. In addition to this, Marmot and colleagues (1998) and Marmot (2006) contend that social gradient embodied in socioeconomic status can potentially indicate health outcomes more accurately. This is because the social gradient captures the nuances of hierarchy in which worst health is found at each gradients sliding down the hierarchy. In sum, the findings overall emphasize put together implies "even comfortably off people somewhere in the middle tend to have poorer health than those above them" (Marmot, 2006, p. 2082). Markedly, three types of pathways, "material, behavioral and psychosocial, should be the [focus] to analyze, with accuracy, outcomes of health" (Marmot, 2006:, p. 2083). The growth in socioeconomic differences in health in the recent years is on rise (see Williams & Collins, 1995, 2013; Barr, 2008), Specific to cause, racial and ethnic differences in morbidity are linked to socioeconomic wellbeing *(see* Crimmins, Hayward & Seeman, 2004; Crimmins, & Seeman, 2004; Hayward, Miles, Crimmins, & Yang, 2000; Williams & Collins, 1995, 2013).

In addition, in the U.S., socioeconomic status is also related to race and ethnicity. Research indicates that racial and ethnic groups with low socioeconomic status consistently experience poor health outcomes (Williams & Collins, 2013). Differential social conditions among racial and ethnic groups are hypothesized as the major causes of health disparity (Clark, Anderson, Clark &Williams, 2013; Gee, Spencer, Chen, & Takeuchi, 2007; Institute of Medicine Report, 2003; Williams &Collins, 2013). For example, between classic non-Hispanic Black and White health differences, many studies have shown that socioeconomic indicators do not completely explain for poor health outcomes among Blacks (Barr, 2008). Even after controlling for socioeconomic status, some differences remain between these two groups (Williams & Collins, 2013; Barr, 2008) that these studies have attributed to other factors, such

as racial and ethnic treatment, gender differences, neighborhood characteristics, access to resources, or socioeconomic gradients among many others.

Similarly, among Hispanics, the relationships between socioeconomic status, race and ethnicity, and health outcomes are explained by the "Hispanic health paradox" (Abraido-Lanza et al., 2005), meaning "the better than expected health experienced by the socioeconomically disadvantaged Hispanic population" (Crimmins et al., 2004, p. 311; Lara, Gamboa, Kahramanian, &Morales et al., 2013). This is an example of variability in SES and race and ethnic health outcomes from the significant evidence of Black and White health outcomes being tied to SES. In addition to this observed variation, the effects of other factors, such as sociocultural and sociopolitical factors, were emphasized as possible influences in explaining for the variation in health outcomes among Hispanics (Abraido-Lanza et al., 2005; Abraído-Lanza, Chao, & Gammon , 2004) Relatively high socioeconomic status among Asians and Asian Americans has been indicated as influencing these groups' good health outcomes (Salant &Lauderdale, 2013), but other factors also seem crucial for explaining their overall positive health outcomes (Takeuchi, Zane, Hong, Chae, Gong, & Gee, 2007).

Conventionally, socioeconomic status has been measured using income, employment status and education. Data from public health literature show that because socioeconomic position leads to the outcomes of social condition, therefore, it is theorized that people's social condition is a function of their socioeconomic status (Link & Phelan, 1995). SES has a consistent association with disease because it is associated with power, prestige, knowledge, and money that can be appropriately used to avoid the risk of incurring disease and death (Link & Phelan, 1995). For example, wealthier/higher SES people's faster access to new information regarding

developments related to health and disease can function as aversion to risk of getting a disease (Link & Phelan, 1995).

At the same time, resources are also context dependent. As noted by Link and Phelan (1995), people who are poor and work in high-health-risk jobs compromise with regard to their exposure to risk and continue to earn their living by staying in these positions. Similarly, immigrants' disadvantages compared to native-born individuals in the labor market are explained by the lack of country-specific skills that range from education to learning the ropes of the host culture (Bye, Horverak, Sandal, Sam, & van de Vijver, 2014; Duvander, 2001; Chiswick, 1978). In this study, U.S.-specific education is theorized as a potential aversion to health risk because of its positive association with socioeconomic status and with favorable outcomes in employment in the host society. The pervasive complexity that is embodied by socioeconomic status therefore requires further investigation for its influence on health outcomes and more specific to immigrants' health outcomes. However, largely due to lack of data availability, most of this evidence is concentrated around understanding Black and White health (Crimmins et al., 2004; Lucas, Barr-Anderson, & Kington, 2003), and more recently, increasingly around Hispanic health experiences (Abraido-Lanza et al., 2005).

Migration and health study: Influence of civic engagement as a socio-political factor and health

In general, civic engagement is classified under socio-political factors. Researchers in the field of health have discovered that civically-engaged communities show positive living outcomes (Ramsay, Whincup, Ebrahim , Papacosta , Morris, & Lennon et al. 2008; Viswanath, Randolph, Steele, & Finnegan Jr, 2006). Evidence show civic engagement has been measured in differential ways in assessing impact on health. For example, Viswanath et al. (2006) found that reproduction of social capital on the basis of staying civically engaged (Putnam, 1995) through

ties to communities of interest contributed to increase in the reception of cardiovascular and other health-related messages. The greater diversity in community integration has a higher chance of increasing people's recall of health-related messages (Viswanath et al., 2006; Browning, & Cagney, 2002). Such relationships lead to people being better-informed about health consequences among members actively engaged in the community (Stephanie, 1999).

Membership in a plural community increases the odds of receiving messages from a wide range of interpersonal networks, media and other sources (Viswanath et al., 2006). The membership in voluntary organizations, such as unions, political parties and religious groups are cited as civic engagement (Skocpol & Fiorina, 2004). Although civic engagement scholarship argues that the varied theoretical references used are complimentary, rather than substantively contradictory, some disparate forms of public participation in democratizing government are based on these three widely discussed frames: the social capital approach, the rational choice approach, and historical-institutionalism (Skocpol, 1997; Skocpol & Fiorina, 2004). Briefly, the social capital approach has combined Durkheim's and other contemporary functionalist approaches, to call it neo-Durkheimian, to illustrate that civic participation lies in socialization of individual members into shared norms and cooperative societal actions (Song, 2013; Kawachi, Subramanium, & Kim, 2010). Rational-choice scholars enquire about whether the participation in governmental or community affairs is socially healthy. Gain and loss are the core meanings implied in rational choice theory (Muntaner, & Lynch, 1999).

Contrary to the neo-Durkheimian approach, historical-institutionalism focuses on the historical growth of civic engagement based on conflict between interest groups and government (Mahoney & Rueschemeyer, 2003; Pierson & Scokpol, 2002; Scokpol & Fiorina, 2004). Analogous to this idea, the rise of democracy is claimed as being historically formed by

organized distrust and conflicts (Scokpol & Fiorina, 2004). Based on this understanding, in this dissertation, civic participation is approached as organized participation in social justice issues related to immigration and general political affairs to promote the democratic health of a nation.

In the context of civic participation and health, a large number of studies have found an unidirectional relationship between volunteer work, pertaining to communities and better physical, mental health and lower mortality (Young & Glasgow, 1998; Van Willigen, 2000; House, Karl, & Umberson, 1988). Furthermore, several scholars find that bi-directionality exists between volunteered public participation and personal wellbeing including superior physical and mental health by analyzing cross-sectional and longitudinal data (Thoits & Hewitt, 2001; Moen, 1992).

While few studies have examined health outcomes among immigrants at the intersection of "adaptation" (as noted earlier, the terms assimilation and adaptation are often used interchangeably by different scholars) and civic engagement (Lee, Ramakrishnan, & Ramirez, 2007), there continues to be dearth of studies contextualizing the U.S.as the context for critical analysis of immigrants' civic and political incorporation. This area of study has gained much attention in the recent years. For example, in their study on immigration and health in Europe, Gele and Harslof (2012) found that because of a lack of adaptation in the host society, elderly African immigrants with low levels of civic engagement have found to experience poor health outcomes. Despite the government's role in facilitating the involvement of elderly immigrants to volunteer for related ethnic organizations, several migration-related disadvantages and structural barriers led to poor civic engagement among African immigrants in Europe. Country-specific language deficiencies, distrust towards organizations and groups, and organizational lack of substantive orientation, rendering information to the volunteers, and aging health conditions

were the primary reasons for low outcomes on civic engagement in the host nation that this study highlighted. Poor health outcomes and low civic participation were both viś-a- viś effected health outcomes among African immigrants (Gele & Harslot, 2012). While remaining engaged in civic behaviors is mostly considered a group level involvement among sociologists, a behavioral practice, nonetheless, embodies psychological orientation among the agents and actors.

Migration and health study: Influence of socio-psychological factors

Studies in sociology and psychology have succeeded in demonstrating links between religious attendance and behavioral and health outcomes (e.g. Eames, 2010; Bormann & Oman, 2010), though the connections have yet to be shown to be causal (Eames, 2010). According to the classic work of Cardwell (1980), religious attendance was dominantly studied by psychologists (*see* Glock &Stark, 1965). Since the 19th century, however, attempts have been made to explore religious attendance from a social-psychological perspective, claiming it as an experiential reality (Taylor, Chatters, & Levin, 2003) rather than behaviorism (Hill, Pargament, Hood, McCullough, & Swyers et al., 2000).

Nevertheless, because of its multidimensional nature, recognized since the 19th century, conceptualizing religion based on social science perspectives has posed challenges among scholars (Taylor, Chatters, & Levin, 2003). Regardless, scholars including Freud, Weber, Durkheim, William James and Marx contributed to an understanding of the role of religion in the social lives of people (Caldwell, 1980). Most importantly, however, as Caldwell (1980) has pointed out, because of the classic foundation developed by Glock and Stark (1965) that included defining the role of religion in civic life, an understanding of religion based on a sociological perspective came to light. Since then religion and its dimensions have gradually fanned out into

different disciplines as commonly seen. In this dissertation my primary involvement will be to unpack religion from sociological and social psychological dimensions.

Religion is one of those socializing agents that attempts to influence and modify the understanding of human beings as narrow and limited biological organisms (Johnstone, 2007). The forefathers of sociology, including Durkheim, Simmel, Shibutani, & Kluckhohn, have tried to define religion. According to Glock and Stark (1965, p.11) the common thread in all of these definitions, and integrated in all of their ideas, is referred to as "value orientation." The additional construct that Glock and Stark (1965) added to their scholarship is determined by further compartmentalization of religion. Religion, as they have tended to describe it, has a values orientation, and "values orientation" is divided between two segments of perspective: the religious perspective and the humanist perspective (Glock & Stark, 1965: p. 11).

Accordingly, Glock and Stark's understanding of religion lays a foundation for seeing religiousness as a social phenomenon (Johnstone, 2007). But religion, as time and again the body of literature in sociology indicates, is considered to lie at the intersection of both a phenomenon and social imagining, potentially leading to a construct that is complex in nature. To be more specific, although Johnstone (2007) describes religion as a social phenomenon modifying biological dynamics, physiological drives, needs, potentials, and limitations, this does not necessarily mean that Johnstone's (2007) argument rejects the interconnections between biology and sociology that religion embodies. This intersection associates further complexity to religion and its interconnected concepts, such as religious attendance. According to Johnstone (2007), "religious attendance usually describes the intensity and consistency of a person's practice of their religion. A person strongly committed to a religious system is concerned about him or herself, first of all, but concerned about others in the group as well" (Johnstone, 2007, p.

96). Johnstone (2007) uses the concept of religion to understand the definition of "being religious," or religious attendance. One way that sociologists have tried to understand religious attendance is to measure it in comparison to other factors. For example, is a religious person different from a non-religious one? In consideration of such binary outcomes by religion, irrespective of their direction[25] and also intertwined with the definition of religion as previously mentioned. Johnstone (2007) argues that either/or definitions such as these leave room for questions when interrogated in the social world with the understanding that the social world is not so neat. Regarding religion as group dynamic, wherein individuals are affected is implicit in nature.

Overall, religious attendance, as Johnstone (2007) expresses, is spread out on a continuum as a phenomenon[26] that connects collectives with individual members. Religion as a phenomenon is a self-constructed entity that transcends the borders of divinity and spirituality. In classic sociological literature religion as phenomenon is described as a natural outcome that is divided into two groups: beliefs and rites. While the former is a set of understandings, the latter is a particular behavioral mode to carry out these understandings (Johnston, 2007). The

[25] To say that directions of religious compartmentalization are different means that while Glock and Stark's (1965) alternative forms of religion, "religious perspectives" and "humanistic perspectives," are attempts to move toward "being religious" distinguishes religion between sacred and profane, which run opposite to each other. While the sacred is religious, the profane is not only in opposition to the sacred, but has no commonality with it. In other words, as Durkheim explains, the opposition of sacred to profane is absolute. Furthermore, the opposition of sacred to profane lies in breaking of the continuity that embodies the degree of religiosity—from being more religious to less. Hence, Durkheim's religion and engagement with it indicates a lack of continuum, i.e., to move from profane to sacred one has to undergo rebirth within the symbolic representation of transformation. This is a contradiction that this dissertation highlights (*See* Glock and Stark (1965) and Durkheim (1915[2008]).

[26] To see religion described as a phenomenon is not uncommon in sociological literature including the classic works. In Durkheim's writings in "The Elementary Forms of Religious Life," he clearly mentions that religion is a phenomenon. Furthermore, collective sentiments are embodied in religious forms and symbols. The religious collectivity or singular entity is not intrinsic to the religiously labeled symbol, but stays outside of the object. It is through phenomenon that individuals and collectives ascribe religiosity to a commonly held object.

endowment of a special nature that religious phenomena are assigned is what qualifies it as a phenomenon; it connects between thoughts as beliefs and actions as rites.

Classical studies have described the role of religion in social integration. For example, Marx and Durkheim both viewed the role of religion in social integration as critical. In immigration literature, the roles of religion and religious institutions are understood as shaping claims for inclusion. Will Herberg's classic "*Protestant, Catholic and Jews*," claims that it is largely by means of religion that immigrants attain an identifiable place in American society (Herberg, 1960). Herberg's writing pertains to the period of mass migration from European nations. On a dissonant note some scholars stress that Herberg's (1960) study is still found to be relevant within the context of "new immigration" since 1965 (Foner & Alba, 2008).

According to Foner and Alba (2008), despite these groups' ethnic similarity with mainstream American society, upon their arrival into the U.S. they were deemed inassimilable and suffered religious discrimination. Protestantism, a largely mainstream religious institution in America, rejected any other religion, especially the Catholicism brought in by Southern and Eastern European immigrants. Nonetheless, involvement with religion was deemed as facilitating a sense of belonging among immigrants in the face of loss, leaving their homelands, families, and relatives behind (Hirschman, 2004). Evidence shows that religion acts as a psychological bastion against the hardships of early adjustment to migration and migrants' experiences of frequent discrimination that lead them to assert ethno-religious affiliations (Foner & Alba, 2008; Kurien, 1998; Hirschman, 2004). In addition to this, ethno-religious involvement facilitates the organization of beliefs, and the formation of communities, co-ethnic networks, social resources, social cohesion and/or social support systems leading to well-documented positive health outcomes (Boreham, Stafford, & Taylor, 2002; Echeverría, Diez-Roux, Shea, Borrell, &

Jackson, 2008; Kawachi & Kennedy, 1997). In this vein, expecting the role of religion and religious attendance influencing modes of integration and tendencies of assimilation among immigrants in any form of relationship with health is very likely.

Except a very recent anthology that examined the role of religion on public health, edited by the sociologist Ellen Idler (2014), studies have rarely investigated the moderating effects of assimilation on the influence of religious attendance and the outcomes of health. In itself, the scholarship at the intersection of religion and public health is not often thought of in combination (Idler & Patton, 2014). Whether in terms of daily, weekly, monthly or annual religious practices, religion has extensive health influences. Increasingly, therefore, texts that attempt to undertake in-depth understandings of the connections between religion and health encourage readers to incorporate religious literacy in twenty-first-century in public health (Idler & Patton, 2014). For example, going back to how religious attendance can inform health, everyday religious practices such as refuge prayers in Buddhism, Taiji in Taoism, yoga and meditation in Hinduism, and Hijabi in Islam are associated with social and psychological impacts on health (Lobsang, Negi, & Ozawa-de Silva, 2014; Reinders, 2014; Yount, 2014).

More explicitly, according to Lobsang and colleagues (2014), refuge meditation functions as a transformative force to help practitioners overcome the destructive force in the body, speech, and mind. However, the transformation of self does not occur simply by reading religious scriptures, but by understanding and following the twofold psychospiritual context of Buddhism: 1) consciousness of mind and body and 2) faith in the Buddha and the *Shangha* (associated community) to transform. In all its senses, as illustrated here, the transformation of self to enhance health and well-being in Buddhism, therefore, lies in meaningfully connecting mind with collectivity that is resonating with the meaning of being both social and phenomenon at its

core (Lobsang, Negi, & Ozawa-de Silva, 2014). Attributed to this understanding, as a social determinant religion is a phenomenon that can potentially influence health extensively (Cohen, 2010; Bormann & Oman, 2010; Lawrence, 2010; Krippner, Friedman, & Johnson, 2010; Coyle, 2010; Flinders, Oman, & Flinders, 2010[27]). Implicit within the process of immigrants' settlement is intersection of immigrants' assimilation and their faith-based practices that is critical to understanding health outcomes. The "invisible" and powerful effect of religion is submersed in faith-based collective practices as social support, social cohesion and social capital (Idler, 2014).

Socialization and outcomes of health

Studies have addressed the relationship between socialization and health outcomes largely with the focus on Hispanic health outcomes among foreign born in the U.S. For example, analyses of acculturation hypotheses addressing Hispanic health outcomes show that traditional socialization patterns among Hispanics, such as greater reliance on family in decision making (including in health care), result in health-related behaviors that buffer negative health outcomes associated with low socioeconomic status (Finch, Frank, & Vega, 2004; Gorman, Ecklund, & Heard, 2010; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Morales, Lara, Kington, Valdez, & Escarce, 2002; Scribner, 1996; Scribner & Dwyer, 1989).

With immigrants' increasing durations of stay in the U.S., studies have found that minorities' health shows differential outcomes with their degree of acculturated social interaction (Landale, Oropesa, Llanes, & Gorman, 1999). For example, Landale et al. (1999) showed that the traditional Hispanic social interaction pattern can affect stress-related health outcomes.

[27] In the context of religion and health, the role of mantra repetition is often performed collectively. Some texts show the importance of Eight-Point-Program (EPP) described and systemized by Eknath Eswaran (2008 as cited in Flinder, Oman, & Flinders, 2010) in his book titled "Passage Meditation." (For some description on EPP and how it heals health, as cited in *see* Flinders, Oman, Flinders, 2010; for details see Eknath Eswaran's book "Passage Meditation").

Women of Hispanic origin who lived with their extended family members during their pregnancies were less likely to experience job loss, extra bills, stressful life events, smoking and drinking. Comparatively, these positively-selected health outcomes had significantly greater association with Hispanic women living with their extended families than with those living with only their immediate family members or by themselves, which relates closely to the U.S. patterning of family formation. Overall, the findings from Landale et al.'s (1999) study indicated that family connections as social support were strong predictors of wellbeing during pregnancy. While individual-level cultural characteristics were weak in their ability to predict group health outcomes, it can be argued that stronger family connections—commonly understood as group-level Latino cultural patterns—can be good indicators of Latinos' health (Landale et al., 1999).

A socialization process by its own meaning expresses a potential social determinant (Sewell, 1964). According to sociologist Sewell's (1964) study, socialization is of recent origin despite the fact that throughout history people were concerned with human beings as social beings. Sewell defines socialization as "the processes by which individuals selectively acquire the skills, knowledge, attitudes, values, and motives current in the groups of which they are or will become members" (p. 163). The fundamentals of socialization theory are rooted in psychoanalytic theory developed by Sigmund Freud in classical psychology. As noted by Sewell (1964), the importance of early life experiences for determining later stages of human development is and continues to be a major force in socialization theory. In this theoretical movement Freud's contribution remains fundamentally and historically important and useful. This dissertation does not intend to elaborate on Freudian theory of socialization, but focuses on more contemporary socialization theory/theories. Furthermore, Sewell (1964) notes that among the four disciplines—psychology, anthropology, sociology and social psychology—while

sociology has made few contribution to the theories of socialization, social psychology is the most recent and emerging. Among these disciplines, however, sociology's contribution is unique and primarily revolves around the influence of social structure on human behavior. Sociological emphasize has been given to institutions, such as "family, the school, the community, primary groups, voluntary associations, and social class structure" (Sewell, 1964, p. 164), which was realized since the dawn of Sociology. According to Sewell (1964), different disciplines have developed socialization theory in various directions, consequently the concept assumed integrated part of a particular discipline. For example, psychology has employed behavioral theory, and anthropology has sought to develop theories of culture transmission. Nonetheless, sociology has also constituted a rapidly developing field in social psychology since 1968, and most of the work cited until 1968 focused on the emotional, intellectual and social development of the child (Deutsch, 1968).

Similar to other social determinants, socialization is a social phenomenon. Yet again, based on scholarly foundation, Ryder (1965) argues, every individual at birth is without any social-psychological structure or ideas or something more formal than buildup. The agencies of socialization are constructed to shape and modify new members to fit the societal design. This social process of construction is not a natural occurrence, per se, but a consciously crafted effort to develop forms of institutions that consistently interact with the life of new members (Ryder, 1965). The family, kinship, peer groups, cohorts, organizations, clubs, fellowships, and associations are all different parts of this constructed structure that play roles in shaping and modifying the individual starting at birth (Paley, 1997; Ryder, 1965). Overall, the constructed socialization process therefore acquires a phenomenological stand based on 'conscious action' (Paley, 1997).

Assimilation, discrimination and outcomes of health

Research on assimilation and health has widely considered two ongoing puzzles. The first is called the epidemiologic health paradox, which examines why immigrants have better health than their U.S.-born counterparts (Abraido-Lanza et al., 2005; Singh & Siahpush, 2002; Bates, Acevedo-Garcia, Alegría, & Krieger, 2008; Landale et al., 1999; Markeides & Coreil, 1986). The second puzzle considers how U.S.-born racial and ethnic minorities lag behind in health outcomes compared to non-Hispanic Whites (Hummer, Powers, Pullum, Gossman, & Frisbie, 2007). Both of these issues concern the "longer duration of living" in the U.S. that scholars have used to measure assimilation in health outcomes across disciplines.

Largely, the assimilation hypothesis indicates that with a longer duration of stay and acculturation and frequent exposure to broader society in the U.S., health outcomes among immigrants deteriorate from the time they enter into the U.S. (Lu, 2010; Akresh, 2007). Research has also found that interchangeable use of assimilation as integration, or incorporation can also have differential effect on the outcomes of health (Berry, 2005; Berry, 1997). Attributing full participation to assimilation in a "nationally" bordered contemporary society, means right to citizenship. Citizenship-status brings along a sense of belonging among immigrants that further utilizes citizenship rights to construct effective assessment of local, regional and national governing bodies towards their community development. As noted by a political scientist, spatial formation by individuals is a function of their significant collective preference, attitudes and behaviors (Reese, 2013). This relationship between collective attitude and local formation can characterize an action and reaction cycle among immigrants and racial and ethnic minorities of color that can potentially determine assimilation tendencies among them. In the societies governed by democratic processes, assimilation is therefore a self-

explanatory variable of effective governance that is socio-politically constructed by collective agencies.

At the intersection of migration, race, ethnicity and health studies, findings show that up until the 1950s, racial issues were discussed largely in terms of Black and White (Foner & Fredrickson, 2004; LaVeist, 2013). In the 21st century, racial and ethnic composition diversified in the U.S (Lillie-Blanton & LaVeist, 2013; Foner & Fredrickson, 2004; United States Census Bureau, 2012). In this vein, assimilation can have differential effects on immigrant groups and racial and ethnic minorities. Influence of assimilation on the health paradox has mainly been addressed by scholars with regard to the Hispanic population; the dearth in Asian assimilation and its effect on outcomes of health is yet to be explored.

Experiences of discrimination and health

The dynamic shift in immigrants' status intersects with race and ethnicity over time stayed in the destination. Race and ethnicity remain central and critical to immigrants' experiences (Foner & Fredrickson, 2004; Lee, 2004; Itzigsohn et al., 2005; Golash-Boza et al., 2006). For instance, a multitude of evidence indicates that public health concerns among immigrants have been influenced by their racial and ethnic categorical and hierarchical living in the host societies (Marmot& Syme, 1976; Abraido-Lanza et al., 1999; Rogers, Richard, Robert, Hummer & Nam. 2000; Singh & Siahpush., 2001; Institute of Medicine Report, 2003; Palloni & Ewbank, 2004; Barr, 2008). Immigrants and racial and ethnic minorities of color continue to experience disparate health risks (Isaac, 2013) because of discrimination and marginalization.. Immigrants of non-European origins experience similar living conditions to those of U.S. born racial and ethnic minorities, conditions which are less likely to be experienced by racial and ethnic groups of European origin (Jones, 2013; Williams & Collins,1995; Williams &

Collins,2013; Xu & Lee, 2013). For instance, it is well known that immigrants who are perceived to be of European descent experience a relatively smaller burden of remnant segregation, discrimination, marginalization, and isolation as compared to immigrants from Asia, Africa, and Latin American countries who contribute most significantly to the ethnic composition of 21st century America (Waller, 2001). Furthermore, studies have found a strong relationship between assimilation (Abraido-Lanza et al., 2005), integration (Berry, 1997), social marginalization, and experiencing "racial insults" and immigrants' health outcomes (Berry, 1997; Wilkinson & Marmot, 2003; Perez, 2008; Nazroo &Williams, 2006, p.256; Lyman & Cowley, 2007; Krieger, 2012). Despite the evidence showing strong association between discrimination and health, non-significant relationship between discrimination and health has been found among African Americans (Broman, 1995), that provides impetus to internalization of discrimination as a reasonable argument.

Social belonging: A means to assimilate and outcomes of health

Generally, studies across disciplines on assimilation and health have used duration of stay to measure outcomes of health among immigrants or racial and ethnic minorities. This study uses measures of social attitude to index assimilation when interviewing paramedics. Rarely has research on assimilation and health outcomes among immigrants or racial- and ethnic-minorities examined the feelings of social belonging as a pre-requisite to assimilation. Additionally, understanding immigrants' experiences of meaningful assimilation i.e., whether and to what extent racial and ethnic minorities will integrate in a society that is racially, ethnically, and culturally different from their society of origin takes into account simultaneous effects of structural discrimination largely associated with "social distancing."

This study is a complementary attempt to provide theoretical weight to both attitude to social belonging and social distance, in order to understand mechanisms of assimilation and health consequences among racial- and ethnic-minority of immigrants of color. Social belonging is defined and used/utilized by scholars in multiple ways to study health outcomes. Cross-discipline definitions of social belonging include: social support (Hale, Hannum, & Espelage, 2005), experiences of personal involvement (Hagerty, Lynch-Sauer, Patusky, Bawsema & Collier,1992), social and psychological functioning (Hagerty, Williams, Coyne, & Early, 1996; Hagerty & Williams, 1999), need (Maslow, 1982), value, and fit (Hagerty et al., 1992; Shibutani & Kwan's 1965), and Yuval Davis's (2011) frameworks.

To map the umbrella concept of assimilation, I will present the applied notions drawn from each theoretical strand by the respective theorists: "experiences of personal involvement and social psychological functioning" (Hagerty, 1992); the social psychological construct of "self-to-others belongingness" at one extreme, compared with "self-to-others distance" and "self-to-others alienation" at the other pole of the continuum, thus determining separation to incorporation on a continuity (Srole, 1956, p.711)[28]; and the connection between social Darwinism and the assimilation paradigm that manifests in the attitudes and behaviors of individuals developing a causal mechanism in assimilation and stratification of racial and ethnic minorities, or "cognitive mechanism[s] embedded in social interactions, not biological differences" (Shibutani & Kwan, 1965). For example, Hagerty and colleagues (1992: p.172) define sense of belonging as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment. Sense of belonging has important applicability for clinical use as well as continued theory development in

[28] Srole (1956) devised a eunomia-anomia continuum that defined an individual's degree of integration within his/her social field.

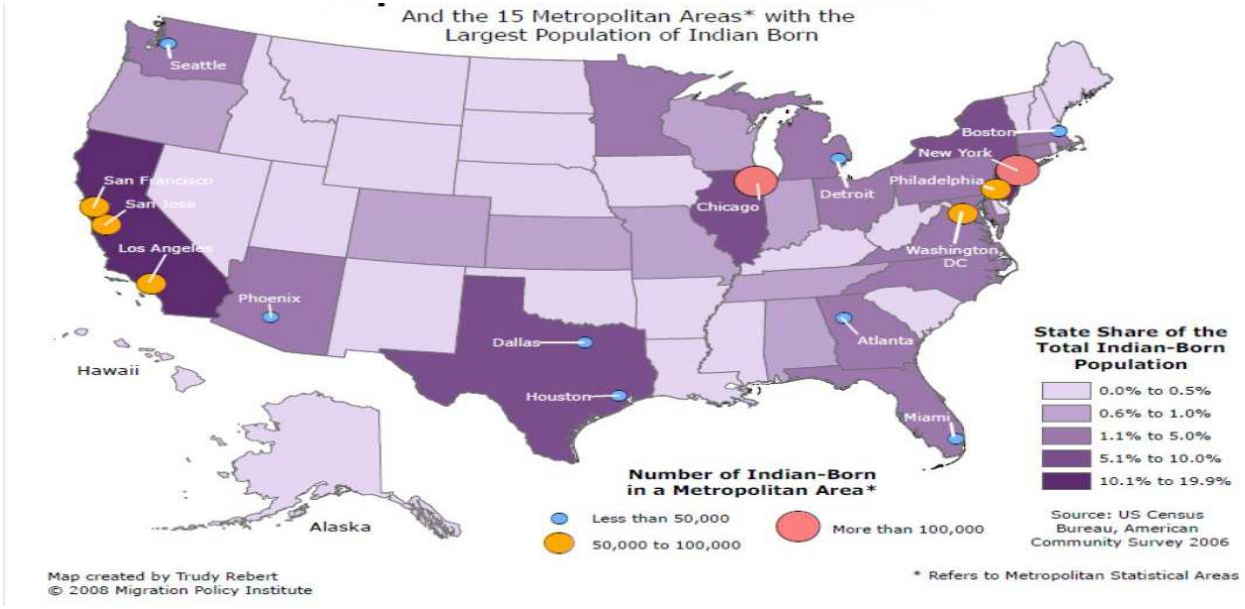
psychiatric nursing." Furthermore, it is indicated that for psychiatric nurses it is an ongoing experience to hear from their patients statements that are attributed to a number of psychological concepts, such as loneliness, alienation, or hopelessness. However, providing an all-embracing concept to image these fragmented emotional experiences, Hagerty and colleagues (1992) use the concept social belonging. Hagerty and colleagues (1992) therefore build a conceptual model to map human relatedness. This conceptual understanding has much relevance if an analogy is drawn for measuring mentality towards assimilation among immigrants and racial and ethnic minorities of color in the U.S. Such mentality can translate into behavioral outcomes and in turn lead to health consequences. For example, focusing on several characteristics of sense of belonging, Hagerty et al., (1992: p.174) illustrate that the consequence aspect of sense of belonging occurs when it is treated as a result of the concept. They propose three features to understand the relationship between the concept and resultant incident: (1) psychological, social, spiritual, or physical involvement; (2) attribution of meaningfulness to that involvement; and (3) fortification or laying down of a fundamental foundation for emotional and behavioral responses.

When it comes to describing a macro level relatedness, grounding the abstractness of space and time across national borders is meaningfully constructed by understanding the basis of forms of attachments. In this respect, this study, in addition, combines social belonging in space and time as defined by Yuval-Davis (2011): the forms of attachments that, instead of remaining as mere contacts, develop a social space of attachment that locates attachment processes and attitudes, in which attitudes identify with the processes. By combining all of these conceptual strands, I have come to define social belonging as a sense of attachment and a feeling of home that goes beyond the stages of contact and culminates into a social space of attachment among individuals. Furthermore, this social space of attachment fosters a convenient process of

attachment while simultaneously encouraging the development of a positive attitude towards belonging to embrace assimilation.

Initiating from this point of attachment, social belonging extends on a continuum from self-to-others belongingness, and social distance encompasses from self-to-others alienation or self-to-others distance. This implies a desire to stay attached, with the assumption and expectation that this attitude will further increase and progress for a given individual. In classical sociological theory, the roots of attachment-alienation theory lie in Durkheim's anomie, Marx's alienation, and Simmel's concept of "uprooted individualism in [the] modern metropolis." However, since the late 20th century, sociopolitical alienation has been approached primarily on the basis of psychological or subjective attitudinal orientation (Reef & Knoke, 1999). Based on this review of literature, the models developed for this study are provided below. The first two models correspond to quantitative analysis of Structural Equation modeling and the last model corresponds to concepts of framing. Broadly, based on this social-psychological perspective, this study explores three overarching research questions:

FIGURE 4: Distribution of Asian Indians by U.S. states



Source: MPI, http://www.migrationpolicy.org/article/indian-immigrants-united-states-

FIGURE 5: Hypothesized measurement model of the study

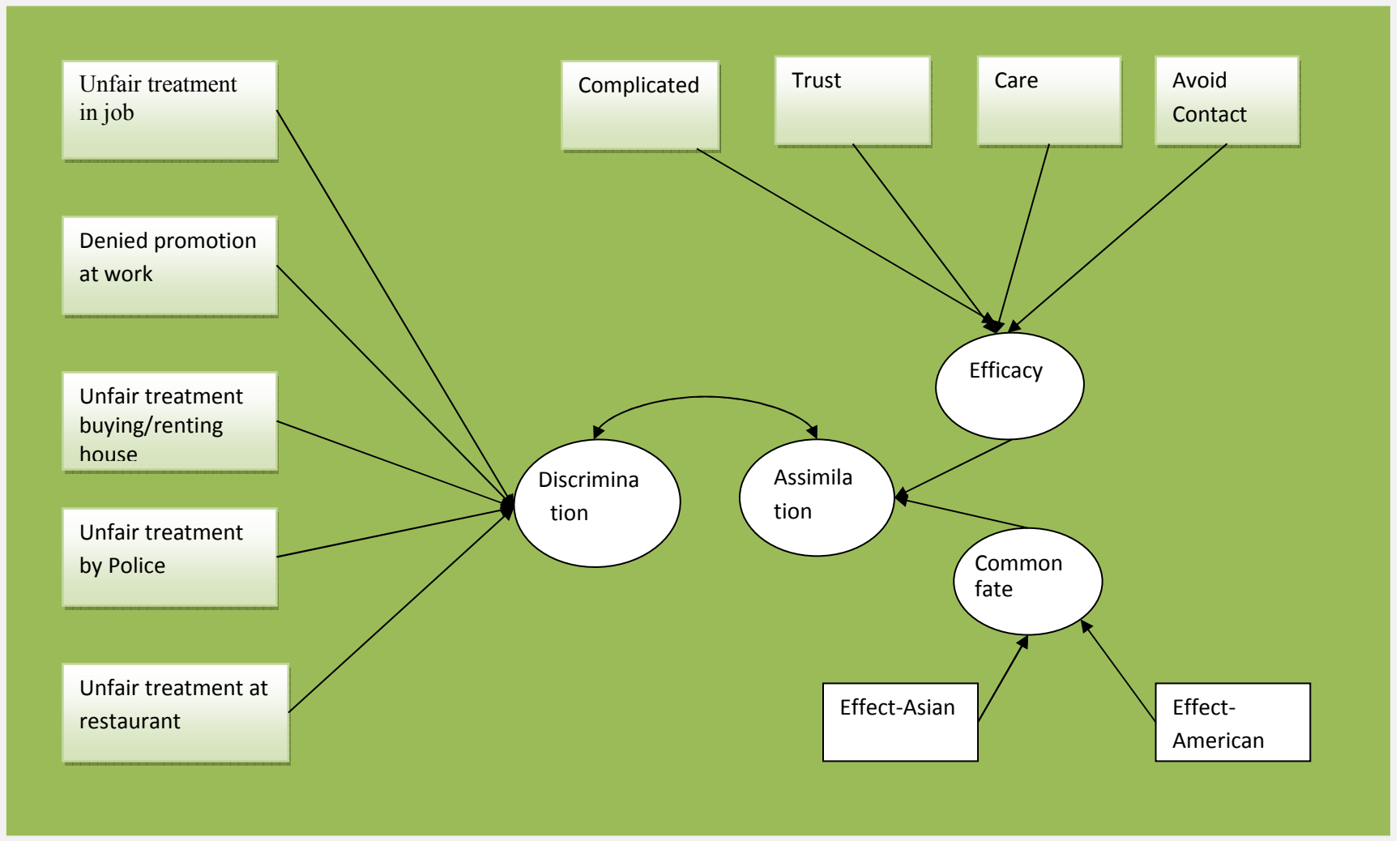


FIGURE 6: Hypothesized moderation model of the study

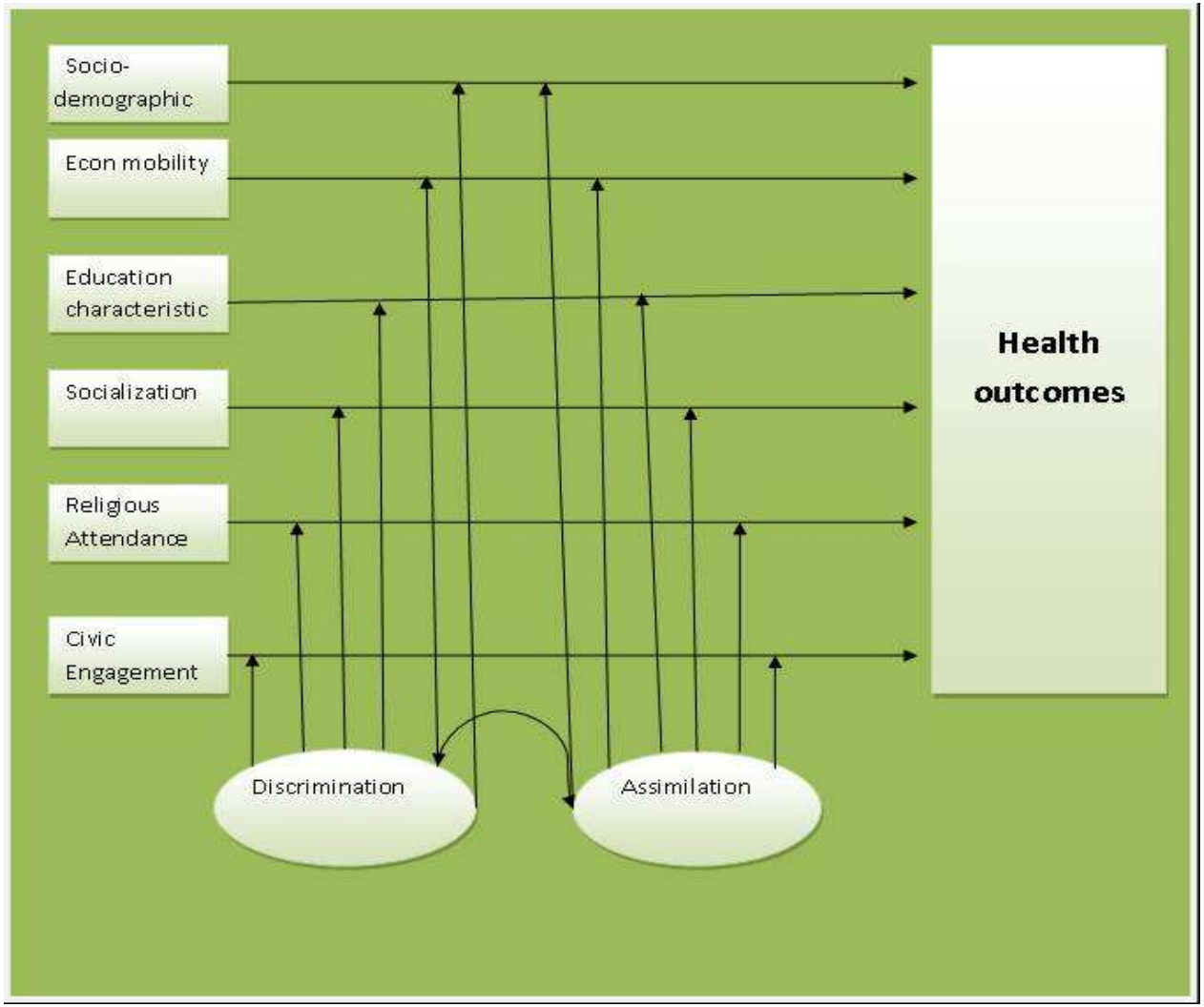
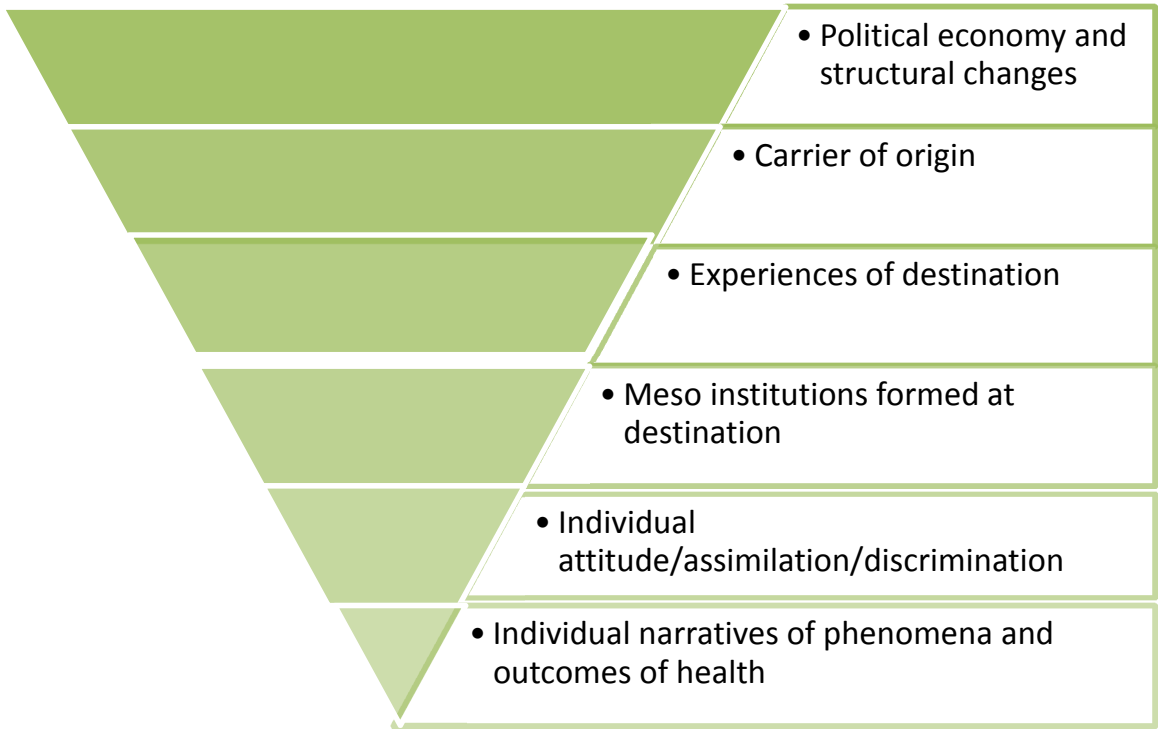


FIGURE 7: Stages of assimilation and outcomes of health among paramedics of Asian Indian origin in the U.S.



Research Question 1: Do efficacy and common fate measure assimilation significantly?

Research Question 2: Whether and how do immigrants of Asian origin use political, social, cultural, economic and/or psychological processes that influence their health outcomes?

Research Question 3: How do immigrants of Asian origin, specifically paramedics of Asian Indian origin, narrate their experiences of health beginning from the process of emigration to settlement in the U.S.?

Specific hypotheses to be tested

Based on these central research questions, several hypotheses are formulated:

(Hypothesized direct affects between independent and dependant variables)

1. Experiences of assimilation, discrimination, and other social determinants (Financial mobility, socialization, religious attendance, civic engagement) influence self-assessed health outcomes among immigrants and racial ethnic minorities of Asian descent.

(Hypothesized moderator affects between independent and dependant variables)

1. Experiences of assimilation and discrimination moderate the relationship between financial mobility and self-assessed health outcomes.
2. Experiences of assimilation and discrimination moderate the relationship between religious attendance and self-assessed health outcomes.
3. Experiences of assimilation and discrimination moderate the relationship between socialization practices and self-assessed health outcomes.
4. Experiences of assimilation and discrimination moderate the relationship between civic engagement and self-assessed health outcomes.

CHAPTER 3

DATA AND METHODS

Data sources: Quantitative data

This study used and analyzed the data on Asian Americans collected by the 2008 National Asian American Survey as part of the Resource Center for Minority Data (RCMD) project (NAAS, 2008). A total of 5,159 self-identified Asians and Asian Americans who are current residents of the U.S. were interviewed. Due to missing data on some of the variables, the final sample size obtained was of 3,451 respondents, which also varied closely due to some missing data on different variables when added to models. The National Asian American Survey (NAAS) is a useful dataset to understand the socio-political participation and other social characteristics of Asian Americans in the U.S., since 2008 elections. The data also include question on global measure of health asking respondents to self-assess their health outcomes including multitude of other social determinants. Overall, the survey instrument included questions about political behavior, attitudes, and personal experiences of immigration into the United States (Ramakrishnan, Junn, Lee, & Wong, 2008). More specifically, I also include questions on attitudes toward government, health and financial status, racial and ethnic identification, linked fate and discrimination, and religious and ethnic social engagements among Asians. The NAAS includes both families in the U.S. and people who indicate having family background in Asia, excluding countries in Middle East.

The total number of population subgroups included in NAAS is 1,350 Chinese, 1,150 Asian Indian, 719 Vietnamese, 614 Korean, 603 Filipino, and 541 Japanese origin respondents, with 182 additional respondents who are either from other countries in Asia, or who identify as multi-racial or multi-ethnic. Overall, 40 percent of the sample chose English as their preferred language for the interview. The sample is weighted, using a ranking procedure, to reflect the

balance of gender, nativity, citizenship status, and educational attainment of the six largest national-origin groups in the U. S., as well as the proportion of these national-origin groups within each state. Demographic information includes age, race, language, gender, country of birth, religion, marital status, educational level, employment status, citizenship status, household income, and size of household. For the purpose of this analysis, the study model included selective demographic measures, which are presented in **TABLE 1** (Cont'd).

TABLE 1: Asian American population demographics[29]

Variables	***N***	***Distribution***
Ancestry or Ethnic Group	5,159	Chinese (24.2%), Indian(21.2%), Vietnamese (13.9%), Filipino (11.7%), Korean(11.5%), Japanese (10.5%), Taiwanese (2.0%)
Year Born(Age)	5,159	1960(2.4%), 1959(2.1%), 1958(2.1%), 1957 (2.1%), 1950(2.4%),
Gender	5,159	Male (53%), Female (46.2%)
Education	5,159	Doctorate (5.5%), Masters, except MBA (18.4%), College graduate (33%), High school graduate (15.9%), High School (15.9%)

[29] The category labels within each demographic item presented here follows conventional ascending order. It is important to note that labeling and coding variables in ascending order (e.g., the label Doctorate is coded as I and High school coded as 5) complies, follows up with, and is based upon matching the intuitive understanding of directionality of a variable. This is unrelated with statistical or quantitative weights. The interpretations of the findings, in this study, therefore follow original coding of the variables as had been coded in the NAAS data set. To see coding of the other variables used in this study please refer to NAAS, 2008 code book.

TABLE 1 (Cont'd)

Employment Status	5,159	Full time(51.2%), Part-time (8.5%), Retired (19.7%), Laid off (1.3%), a student (2.7%), homemaker (7.0%), permanent disabled (0.7%), unemployed (2.9%)
Income	5,159	$150,000 and over (9.0 %), $125,000 to $150,000 (3.9 %), $100,000 to $125,000 (7.4 %), $75,000 to $100,000 (8.6 %), $50,000 to $75,000 (10.7 %),$20,000 to $35,000 (7.3 %), Up to $20,000 (8.3 %), Don't Know (13.4 %), Refused (23.9 %)
Nativity	5,159	U.S. Citizen (75.6%), Green Card (14.7%), Visa (2.8%)[30] Skip/Don't know, Refuse (7%)
Religion	5,159	Christian (17.2%), Catholic (16.8%), Hindu (16.6%), Buddhist (15.0%), Muslim (0.3%), No religion (19.7%),

Since 2009, the goal of White House Initiative on Asian Americans and Pacific Islanders (WHIAAPI) is to advance data collection, analysis, and dissemination of AAPI community to foster federal agency plan ('Initiatives on Asian Americans and Pacific Islanders: Issues and facts', n.d). In public health research, data limitations were fulfilled by a combination of multiple data sets. One example along this line is the examination of health outcomes of racial ethnic minorities in the U.S. by combining NLMS and NHIS data sets to understand cause-specific health outcomes (Singh & Siahpush, 2002). As NAAS, is not a comprehensive data set to examine health related behaviors (smoking, drinking, diet and physical activity) and cause-specific mortality, to ensure that this dissertation, addresses this gap I used qualitative or oral history interviews. The interviews were obtained from 16 nurses and physical therapists of Asian Indian descent, in which there are 3 males and 13 females. It is assumed that due to the nature of employment the selected female paramedics are expected to be higher than number of males. More details on qualitative data are provided under qualitative data section. Furthermore, because of containing measures on self-assessed health that is gaining popularity in

[30] Among 2.8% visa holders, H1B=1.0%, H4=0.1%, F (student)= 0.5%, Other=1% and rest refused/ skip/don't know.

understanding health outcomes from a bottom-up approach or patient driven rather than physician driven approach, this data set is comprehensive in allowing researcher to use phenomenological approach to the analysis of data. Ultimately, the National Asian American Survey is a comprehensive and useful data set because it contains global measure on health, measures on socio-political attitude, structural experiences, and behavioral patterns as proxy to assimilation. As a national representative sample of race and ethnic sub-populations, this data set is important and significant.

Measures

Dependent variables

Self-assessed health outcome is the dependent variable in this study. A growing body of current research shows that health can be defined and measured in various ways. Hence, the adoption of a multi-dimensional approach to understanding health (Barr, 2008) is also a meaningful way to approach health status for racial and ethnic minorities. Rejecting the earlier concept of health as a biological construct only, this research approaches race and ethnic health as a social, psychological, and overall feeling of well-being. This study use the global question measuring health from the National Asian American Survey (NAAS) of 2008, which asked respondents "How do you rate your overall physical health?" to measure their health outcomes. The variable is measured on a Likert scale: excellent, very good, good, fair, or poor. The global question on self-assessed health is the only measure for health among Asian Americans in NAAS data set (NAAS, 2008). The question is measured by the variable G2 in NAAS. The total number of response received on this question is 5,159. Close to $3/4^{th}$ of the total cases fall within the range of excellent to good overall physical health status (NAAS, 2008). The variable is coded in increasing order measuring excellent health =5 and poor health= 1. The missing cases

have been excluded from the analysis of data and no other modifications have been applied to this variable.

Moderator variables

In this study, assimilation and discrimination are both independent and moderator variables. As indicated by the research question, this study analyzes how Asian Americans self-assess their health outcome as they experience assimilation and discrimination. Literature on assimilation and discrimination has rarely examined the interaction effects of social determinants on outcomes of health among population of Asian origins. Based on the assimilation literature, assimilation can be conceptualized and measured in various ways. A linear and broader understanding of assimilation assumes that an individual's closer resemblance to the Anglo-Saxon population, or White Anglo Saxon Protestant (WASP) sociocultural, behavior, and socioeconomic standards, would imply greater assimilation. On the contrary, distance from Anglo-Saxon/WASP standards would mean less assimilation.

Literature also indicates an inverse relationship between immigrants' assimilation and outcomes of health. For example, the healthy migrant effect hypothesis notes that while immigrants have better health outcomes as compared to Anglo-Saxons, with longer duration of stay in the U.S, immigrants show poorer health outcomes. Research on both immigration and race and ethnic health have primarily used variables such as duration of stay (Cho, Frisbie, Hummer & Rogers, 2004; Goel, McCarthy, Phillips, & Wee, 2004), English language use (Salant & Lauderdale, 2003), and dietary habits as proxy to assimilation. Rarely, attitudes on socio-political participation have been used as measures of assimilation. Assimilation as developed by Milton Gordon's thesis (1964) indicates seven indicators: acculturation, structural assimilation, marital assimilation, identification assimilation, attitude reception assimilation, behavior reception assimilation, and civic assimilation. As Milton Gordon's (1964) theory of

assimilation is well recognized in American sociology as the foundation of assimilation theory, the measures used in this research are initially borrowed from Gordon's work. These measures are: attitude reception assimilation, behavior reception assimilation, civic assimilation. The measurement model also used items based on these three forms of assimilation to measure latent variable assimilation.

Attitude, behavioral, and civic assimilations

According to Gordon (1964), attitude assimilation occurs when racial and ethnic minorities feel absence of prejudice towards the mainstream culture. Behavior assimilation occurs when minorities assume no experiences of discrimination directed towards them. Similarly, civic assimilation occurs when there is an absence of values and power struggles. Civic assimilation has received little attention in the assimilation literature (Bloemraad, Korteweg, & Yurdakul, 2008) assuming the lack of attention extends over individual-to-structural continuum i.e., attitude to structural formation in the context of political incorporation (Ramakrishnan & Espenshade, 2001). For example, Bloemraad and colleagues (2008) argue that within assimilation literature, "cultural assimilation, social integration, and economic mobility receive primary attention; civic and political integration are secondary."

Measuring assimilation

In the quantitative analysis of this study, assimilation is constructed as a latent variable and measured by using socio-political efficacy and common fate items. Encouraging more understanding into political participation, Bloemraad and colleagues (2008), argue that political participation can potentially facilitate socio-economic mobility if immigrants and their children can lift institutional barriers by using political power (Bloemraad et al., 2008). Additionally, an increase in political participation intersects with other social forms of socio economic mobility

and social resources (Ramakrishnan & Espenshade, 2001). It is widely known that people and groups with high socioeconomic status are likely to participate more in politics.

As this research uses NAAS 2008, which has opinions on socio-political behavior of a nationally representative sample, socio-political efficacy was developed using measures of political attitude and behavior. In particular, socio-political efficacy items measured respondents' attitudes on civic and political engagement. The measures were weighted using Likert scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree). For example, "Sometimes politics and government seem so complicated that a person like me can't really understand what's going on;" Out of 5,159 total cases, which is also the total representative sample of Asian Americans in the U.S. who responded to NAAS 2008, approximately 50% or more firmly agreed that U.S. politics is complicated. Close to a total of 8% refused to give any opinion or indicated no knowledge of politics. The variable is coded in ascending order and positive direction, 5=strongly agree and 1= strongly disagree.

Besides including QG5_A labeled as "politics is complicated," other observed variables of efficacy drawn from NAAS 2008 are: "QG5B as Trust in Government," "QG5C as Politician care what people like me think," and "QG5_D people are better off avoiding contact with government (See NAAS, 2008 code book for descriptive/frequency on these categorical variables)." Out of a total of 5,159 cases, 48% respondents believed that politicians care what people think. Around 12% of respondents either did not know or skipped the question. Almost 30% of the cases fell under disagree to strongly disagree. Respondents who trust the government are close to 50% which is equally comparable to those who do not trust the government. In regards to avoiding contact with the government, while almost a 50% did not support supporting the government, only about 17% supported avoidance. All these items measuring attitude are coded in increasing order and positive direction, 5= strongly agree and 1= strongly disagree. The

common fate items involved whether the respondent feels that issues with other Asians affect their life; how these issues affect their life, and whether they feel that what happens to other (ethnic) Americans affects their life. Furthermore, common fate is observed by two, in-group and out-group feelings, which are labeled as QF2A_1indicating "What Happens to Other Asians will Affect a lot, some, not very much, not at all; and QF3A_1 indicating "Do you think what happens to other Americans affects a lot, some, not very much and none to what happens to your life" variables. The variables labeled QF2_1 and QF3A_1 are recoded as a new variable from originals QF2 and QF2A and QF3 and QF3A respectively, in which the original variables for each constructed variables are divided between the main attitude measuring statement and effect size. By applying the "if condition" in SPSS all respondents who answered "yes" to QF2-other Asians effect my life- "a lot" and "some" and those who answered "no" were applied the "if condition" to be grouped combining "not very much" and "none." Similar process was applied for combining both QF3A and QF3A_1 as well.

The rationale behind choosing attitudes towards socio-political behavior for "efficacy" and "common fate" substituting attachment and alienation to measure assimilation is illustrated in the following paragraph. According to Ruesch, Jacobsen, and Loeb (1948), the conceptual development and the definition of the theory of assimilation by Gordon (1964) reveals that assimilation includes elements of attitudes, beliefs and values that overlap with acculturation (as cited in Rudmin, 2009). According to Rudmin (2009), acculturation can be considered as a sub-classification of the theory of assimilation considering the broader definition of the theory. Borrowing from and expanding on Ruesch and colleagues'(1948) idea, Rudmin (2009) indicates that attitude is constructed as a continuum if viewed as an extension from one culture to another; good to evil, desirable to undesirable, and acceptable to unacceptable are considerable ranges , which can be considered as extending from one culture to another. Cultural broadening negates

the assumption of discreet and differential existence of behaviors, thereby posing a continuum. Following Rudmin's idea, in this study, I constructed assimilation based on attitude items. As noted, provided there is theoretical support that connects assimilation and attitude, measuring assimilation on the basis of attitude is assumed valid in this study. Furthermore, additional support for the selection and use of attitude items to measure assimilation in this study is borrowed from the descriptions in "Inventory of Social Attitudes" *(for details see* H.J. Eysenck, 1951 cited in Knight, 1999 p.99). Possessing an axiomatic power, "Inventory of Social Attitudes" is self-explanatory in the use of attitude towards depicting any social behavior. Furthering the argument, the conceptual framework adopted in classic assimilation by Gordon (1964) also provides some support to the use of socio-political attitude to measure assimilation. As the definition of assimilation includes acquisition of culture, behavior, and membership in clubs and cliché of Anglo-Saxons' or broader/core U.S. society, at the micro level attitude functions both as out group and in group phenomenon. Based on this explanation, therefore, I provide theoretical justification for the use of constructed elements of assimilation that have been used in this study. To test the theory, in the empirical study, the research question posed states: Are efficacy and common fate reliable measures of assimilation in the U.S.?

Belonging framework: Citizenship and assimilation

The qualitative portion of the assimilation study is constructed and measured using a belonging framework. Adopting a polity perspective, Aleinikof and Rumbaut (2011) have expressed that the U.S. is a "nation of citizens" rather than a "nation of immigrants." In this dissertation, from its onset, I have described the U.S. as a nation of settlers based on socio-historical measures. This notion of settlers applies more firmly to European immigrants, rather than the commonly held belief about the Mexican immigrants in contemporary scenario of

illegally crossing the border to enter into the U.S. The concept of nation-states has left no alternatives from reduced globalization to the markings of obtaining citizenship as measures of right. In migration studies, a sense of belonging as applied to the process of assimilation has mainly focused on acquisition of citizenship, a socio-political membership validating the notion of belonging (Bloemraad et al., 2008; *see* Bloemraad et al., 2008 for the definition of citizenship). However, the bounded construct of citizenship has been brought under debate by globalization scholarship. For example, according to Shafir and Brysk (2006), citizenship as a traditional form of right has been limited from the lens of globalization. Instead, a new form of right that is broader in its reach has emerged by the virtue of globalization and is called human rights. In the context of belonging, globalization pursues an universal right (Shafir & Brysk, 2006), assimilation is restricted by power, and belonging emerges as a more liberal version of the rights issue. For example, an insight into the U.S. health care access from the lens of equitable globalization suggests that rights issues transcend the borders of citizenship, embracing human rights to provide health care for all, irrespective of U.S. citizenship status.

Between the traditions of citizenship vs. human rights, belonging encompasses the rights of citizens that are associated with social, economic and cultural dimensions (Shafir & Brysk, 2006) in relation to scaling or level (Sassen, 1998). While the concept of assimilation lies on a binary frame of transformation, belonging to assimilation presumably lies on a continuum (Srole, 1956). Belonging is in a continuous process of formation that includes experiences of discrimination (Gordon, 1964) across class and race (De Castro, Gee, & Takeuchi, 2008; Bonilla-Silva, 2006).

Discrimination and sense of belonging

Individuals who often experience and are likely to experience discrimination in a race conscious society are expected to maintain social distance from assimilating into the host nation. This is a socio-psychological processing which is in conflict with the "sense of belonging," hence aligned with discrimination. The multiple items on discrimination are: has the respondent ever been unfairly denied a job or denied a promotion at work? Unfairly treated by the police? Unfairly prevented from renting? Treated unfairly in restaurants? The selected items are measured on a Likert scale (ranging from strongly agree to disagree; without a 'neutral' measure) and are selected to index discrimination; therefore, they correspond to experiences of unfair treatment.

The theoretical underpinning used to develop the discrimination index is drawn from Srole's (1956) explanation of social distance that describes a continuum between assimilation and social distance (*See* Srole, 1956 *for details*). Marginalization items are used to construct the latent variable discrimination. The degree of discrimination can shed light on what happens to health among racial and ethnic minorities of Asian descent when they are marginalized in the U.S. In addition, the findings will answer the question of whether or not discrimination serves as a moderator in the relationship between religiosity, socioeconomic mobility (getting along financially), and socio-demographic (race and ethnicity) characteristics and health as the outcome variable. Rarely, in migration and health hypotheses previous research has looked into the moderator effect of assimilation and discrimination simultaneously; this study, hence attempts to understand if immigrants' health outcomes are modified by interaction effects of assimilation and discrimination. In addition to this, and as stated earlier, model minority theses (Thrupkaew, 2002) have generated debate about Asians from acquiring polity parity in affirmative action and the ceiling effect in attaining promotion in their jobs.

Independent variables

The race and ethnic health literature has emphasized the measure of health as a multilevel and multidimensional construct. For this reason, in this dissertation health is examined as an outcome of a multidimensional social construct; this study uses predictor variables developed from multiple dimensions and levels. The primary independent variables that I propose to use in this study are: financial status, civic engagement, socialization pattern, religious attendance, and socio-demographics. Multiple items have been drawn from NAAS 2008 to measure each of these constructs. The rationale behind selection of these items is discussed below.

Financial status

In the U.S. immigration history, rarely reforms have been written considering needs and interests of the immigrant laborers or their settlement and integration patterns in mind (Chiswick & Miller, 2012). In particular, when compared to the other traditional migrant-receiving countries in the West, U.S. reforms are more focused on the ways to restrict immigration than their means of development (Chiswick & Miller, 2012). Based on both historical and contemporary evidence of Asian immigrants' presence in the U.S., it is, however, widely known that most Asian influxes were driven by the type of labor demand existing at the time of migration. Low-skilled menial jobs unwanted by many natives are mostly occupied by either immigrants or by native-born racial and ethnic minorities in the U.S. This data does not point to the lack of presence in low or high-skilled immigrant laborers in the U.S. Furthermore,, current immigration reform under the Obama administration is largely focused on attracting high-skilled immigrants to the U.S (Martin, 2013); to which Michael Fix (as cited in Martin, 2013) refers to as market based strategy in immigration overhaul. Nonetheless, immigrants' skills and education/training brought from the country of origin often do not transfer completely into the

U.S. (Chiswick & Miller, 2012). In light of this skill-mismatch concept, the item selected from NAAS 2008 for this study asks respondents if all of their formal education took place in the U.S. It is assumed that U.S.-specific education will potentially increase the gains on socioeconomic assimilation and, consequently, provide an advantage in regards to health outcomes (Williams & Collins, 2013; Barr, 2008; Link & Phelan, 1995). The variable measuring financial status is labeled and described as: QG_1 "We are interested in how people are getting along financially these days. Would you say that you (and your family) are better off, worse off, or just about the same financially as you were a year ago?" This variable was constructed using the original question: QG1A asking "We are interested in how people are getting along financially these days. Would you say that you (and your family) are better off, worse off, or just about the same financially as you were a year ago?" The question is further categorized in subparts dividing total respondents into two categories. One is labeled as QG1A, "much better or somewhat better?" and the other question labeled, QG1B, "much worse or somewhat worse?" The final variable entered into the model was a combination of QG1A and QG1B. As a result of recoding, while the original variable QG1 had three categories, better off, worse off or just about the same, the recoded variable, QG_1 have five categories. The variable QG1 was re-coded into a different variable. All those who belonged to the category "better off" were further categorized applying "if condition. For example, if QG1 = 1 then QG_1= QGB. Similarly, if QG_1=2, QGC=QGA. This recoded pattern was applied to all the variables which were re-coded into new variable to obtain final variables with combined categories in this study.

Socialization pattern

Socialization pattern is incorporated first as a group-level construct. Then socialization with families has a greater implication on influencing health outcomes among racial and ethnic minorities living in the U.S. For example, the sense of familism noted and critiqued among

Latinos and Asians by mainstream WASP culture as hindrance to socioeconomic advancement has, to the contrary, been found to influence positive living outcomes (Landale et al.,1999; Juang & Alvarez, 2010). According to the recent study on Chinese adolescents, Juan and Alvarez (2010) found that greater family cohesion leads to less adolescent isolation. The selected NAAS 2008 items measuring the socialization variable are dichotomized: if given an hour, whether respondents will spend more time with family/ friends or at work. The original variable labeled QC14 illustrated "If you had one extra hour per day, how would you spend it? For example, would you spend more time with family and friends, more time at work, or something else?" Two dichotomized variables were constructed out of QC14 by combining two separate categories: QC14_D1 and QC14_D2 each of them asking following questions respectively. 1. Socialization within family (1) vs. others (0), and 2. Socialization at work (1) vs. others (0). The procedure followed to recode and construct these variables is basic recoding process as is allowed by SPSS. The variable is dichotomized.

Religious attendance

Religious attendance was added as another social determinant to understand health outcomes. The item asking "how many times respondents visited their religious institution in a week" is included to measure religious attendance. In his currently published anthology, sociologist, Ellen L. Idler (2014) indicates different timings in religious practices and their greater association with health. For example, different forms of daily, weekly, annual and one-time religious practices are associated with implications of health outcomes. QH2 asks respondents "How often do you attend your place of worship: at least every week, almost every week, a few times a month, only a few times during the year, hardly ever or never?" Based on frequency distribution of respondents, while almost 27% felt that the question does not apply to them, a more than a half indicated spending some time in their places of worship. The selection

items ranged from and coded in a reversible order: 1. At least every week: 1193 (23.1 %); 2. Almost every week: 611 (11.8 %); 3. A few times a month: 593 (11.5 %); 4 Only a few times a year 711: (13.8 %); 5 Hardly ever

Civic engagement

Another social determinant added in the study is civic engagement. The local- and global-level civic engagements are measured by the answers to the following questions: 1. Did you take part in immigration marches in spring of 2006; 2. Did you send money to the country(ies) from which people took part in the march?; 3. Did you contact family and friends in/from that country?; 4. Participated in any activity dealing with the politics of that country? and 5. Do you have plans to become a U.S. citizen? The items were included separately in the study because of low alpha and correlation. The only items used in the study are 1 and 4, rest were dropped due to poor correlation. In dealing with the politics of the country of origin, 95.4% responded no and similarly, almost a 98% people said that they did not take part in immigration march. Both the items are reverse coded with yes=1 and no=2 and used in this study's analysis keeping the original version intact.

Socio-demographic measures

Socio-economic and demographic measures are used as covariates or control variables. For this study, I will focus on the following measures: household size (including minors 18 years of age and below), gender of the household head, age of the household head, gross household wealth (pretax income in dollars), employment status, education (highest level completed in years), marital status (married or living with a partner, divorced, widowed, single?), religious background, residency status (own or rent), legal status (citizenship obtained), duration of current legal status (year since obtaining citizenship), age at obtaining citizenship, and nativity

(visa or green card holder or U.S. citizen). Direct influence of major socio-demographic measures is analyzed and their influence on health outcomes on Asian descents in the U.S. is reported.

Sociological research has used the conceptual frame of assimilation and transnational practices have been utilized to understand the formation of racial ethnic identity. Research indicates that construction of identity among racial and ethnic minorities is multi-dimensional and multi-causal (Waters, 1999; Portes & Rumbaut, 2006; Feagin & O'Brien, 2003; Bonilla-Silva, 2006). For example, Waters (1999) defines identity as a social construction of self that evolves in respect to its broader context. According to Waters (1999, p. 112), "social identities are not concrete existence…instead, identity is a conception of the self, a selection of physical, psychological, emotional, or social attributes of particular individuals; it is not an individual as a concrete."

In addition, based on classical scientific research, pseudo-scientific discoveries claimed that race is a biologically determined inert category that is meaningful when arranged hierarchically (*see* Barr, 2008). To further assert this concept, the eugenics movement attempted to validate race both as a biological category that is inherently hierarchical. Entry of social science and further discoveries in social science research, however, found that race is a dynamic process in which the categories of race, which includes ethnicity, has remained socially constructed and changed over time. Because of this non-existentialist position, race and ethnicity conceptually and primarily followed a combination not limited to biology and culture extending to various other forms of social patterning of race and ethnicity. In tandem with different measures of socially constructed race and ethnicity, studies have found differential outcomes of racial and ethnic health (Isaac, 2013; LaVeist, 2013; Williams & Collins, 2013;

D.Williams & C.Collins, 2013; Clark, Anderson, Clark & Williams, 2013; Paradies, 2013; Barr, 2008).

The 2008 (NAAS) allows respondents to select from broader/hyphenated racial and ethnic identity categories (African American/Black, Asian/Asian American, etc.), as well as multiple discreet categories of specific Asian origins (e.g. Chinese, Indian, and no Asian group) about their consideration of race and ethnicity. The NAAS 2008 data set classifies respondents into seven ethnic categories: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asians. In this study, self-assessed racial and ethnic identity is used as an independent variable.

Consequently, race and ethnicity are added as an independent variable and this item is coded into "dummy" variable with numerical assignments of 1 and 0: subjects who select identities in any Asian-origin categories are coded as 1, and those who select Asian American identity are coded as 0. In addition, by demographic majority some of the Asian subgroups are separated out as a dummy variable and coded as 1 vs. 0, in which 1 is a major subgroup, such as Asian Indian or Chinese vs. others. The race and ethnicity variable is divided into cultural and racial underpinnings. The variable labeled as qa_D1 to qa_D5 asks ancestral or ethnic origin of the respondents. The variables are divided into Chinese, Indian, Filipino and Korean vs others as a dummy variable. Similarly, qs_d1 to qs_d2 labels Chinese, Indians, Filipino, Vietnamese, Japanese, and Asian vs. others. Each variable is constructed as a dummy variable. Marital Status, citizenship status and employment status were added as controls. These variables are all dichotomized. Gender was not controlled for as adding gender reduced the sample size from 5000 approx to 300. Therefore, the loss of sample size was adjusted for by removing gender.

Qualitative methods

This study also uses a combination of phenomenological analyses and oral history interviews to obtain data. I used a phenomenological approach to analyze qualitative data because unlike other methodological orientations, phenomenology completely relies on interviewees' verbatim responses rather than solely on the researcher's own interpretations. The emphasis on verbatim details allows the researcher to achieve greater scientific rigor and "detailed exploration of the contents and structure of consciousness" (Throop & Murphy, 2002, p.191) from respondents. According to Throop and Murphy (2002), the constructive intent behind grounding Husserl's methodology, which emphasizes individuals'/respondents' explanations of the experiences of the events, within phenomenology was to fill in the gap in what was presumed to be a problematic aspect of western investigation of science. This investigation often relied upon unquestioned assumptions and taken-for-granted methods of examination. Therefore, this study also uses an oral history interview technique derived from phenomenology that "grounds philosophical assumptions in systematic and scientific examination of the contents and structures of lived experiences" (Boland, 1986, p. 45).

Qualitative methods: The need for phenomenology

To contextualize self-assessed health based on the question " How would you rate your overall physical health?" this study facilitates self-assessing consciousness among the respondents in relation to their health. Consequently, connected to this aspect of self-consciousness is a social phenomenon because of what I call parameters of "self-assessed health" that is the focus of this study, as phenomenological response.

Recently, phenomenology has gained popularity in nursing research because of a growing disparity observed between nursing philosophies for providing health care vs. western mode of

research method in nursing research (Benner, 1994; Ray 1990), which is more closely related to logical positivism of outsider's view. As health care service workers, nurses and therapists employ a holistic philosophy, interactive maturity of work ethic, and epistemology by serving human (Benner, 1994). More importantly, the research question that guides phenomenological method primarily asks about human experience (Lo-Biondo-Wood & Haber, 2014).

A comprehensive approach to study race and ethnic-driven experiences of healthcare service providers can most appropriately rely on phenomenology. For example, Lo-Biondo-Wood and Haber (2014) note that phenomenological methods are applied to questions, such as "How do women move through menstrual to post-menstrual life?" in nursing or clinical studies. While application of phenomenology discussed in nursing research mainly concentrates on improving clinical studies, interventions and patient care, adopting a meta-analysis approach relevant to social psychology is crucial, critical, and holistic to examine health related experiences of nurses and therapists who are the primary service giving agents. The nursing and therapy forms of service giving requires the shifting of methodological attitudes of the researchers to fit the holistic approach to match the context of service giving prevalent among nurses and therapists and the approach of the researcher to study insider phenomenon. Furthermore, Lo-Biondo-Wood and Haber describes that the focus of the phenomenology researcher is the "lived experience;" this characteristic of phenomenology is likely to instigate study of day-to-day lived experiences of a particular group.

A researcher's role in phenomenology is bracketed. A compelling explanation of bracketing is "the researcher identifies their own personal biases about the phenomenon of interest to clarify how personal experience and belief may color what is heard and reported (Lo-Biondo-Wood & Haber 2014, p. 113). Aligned to this idea, an insightful approach rooted in the development of phenomenology calls for integrating into an emic (insider) view rather than etic

(outsider) view. In contrast, quantitative analysis of behavior highlights positivist mode or deduction from the respondent's story. From an absolute philosophical stand point, Beck (1994) describes that in phenomenology, the researcher's self is baseline to collect data and the researcher's "bracketing" is essential (Beck, 1994). In its own sense, phenomenology as a form of ethnography affirms that researcher adopting this method should embrace human experience in its wholeness and should believe that each "unique human being attributes meaning to his and her own context and the experience evolves from his or her social and historical context" (Lo-Biondo-Wood & Haber, 2014 p. 110).

It is usually said in the context of using phenomenology that the participants in a phenomenological study are selected purposefully and the members of the study are either living the experience or have lived the experience in the past. As phenomenologists believe that a past experience is lived in the present, a past experience exists in the present and is lived through remembrance at the time of the interview. Even when the participant is using a past experience, the information is gathered at the present during the time of the interview. For this study, the data was ultimately collected using the oral history narrative method. However, the oral history framework used in this study can be classified under the broader description of the phenomenology tradition of memory-based lived experience.

To this end, this study explores the first-hand experiences of the respondents who are living in a mobile racial- and ethnic-minority context. Furthermore, as this study attempts to understand how immigrants of Asian descent feel about their health when living over time in the U.S., this context demands a thorough and systematic investigation of their experiences. Oral history interview questions such as: "Reflect upon your own experiences starting from the point in time you decided to migrate," focuses upon understanding respondents' migration experiences as a historical process. Included in this study is immigrants' self-assessed health statuses is

measured by asking, "How would you describe the changes in your health status starting from the time you entered into the U.S." Reflected through these specifics is an interpretive methodological paradigm that builds off of Clifford Geertz's (1973, 1994, 2000) work and a hermeneutic tradition that is more interested in collection of personal narratives (Guest, Namey, & Mitchel, 2013). As such, this study inclines toward an interpretive perspective with the core idea that behavioral study relies on multiple realities versus one objective reality. This study, therefore, focuses on individual experiences translated into socially constructed processes. As part of phenomenology, to retain the experiences or data in its entirety from a purposive sampling and collecting of past data by being in the present, the traditional methods of note taking and the modern method of recording was used.

Understanding of experiences of discrimination and its consequences in the work place and everyday life, family and work dynamics, identity formation, socio-demographic and socioeconomic mobility, religiosity etc. among paramedics of Asian Indian origin as a subset of immigrant population or racial and ethnic minorities of color can be extrapolated to immigrants of Asian origin based on the common denominator of Asian background and its treatment in the U.S. as minorities of color and both low and high skilled labor immigrants.

Qualitative methods: The need for using oral history narratives

An important observation emerged during the process of carrying out this research that necessitated the need to incorporate oral history in the interview process. Memory reliance was necessary in the process of amplifying immigrants' experiences, since their entrance into the U.S., in the following contexts: making the decision to immigrate, past, ongoing, assumed or perceived experiences of discrimination, sense of belonging as assimilation, socialization with family, friends and at work, financial status, religious attendance, civic participation including

other social determinants and their influence on health status of Asian Indian immigrants. Because this data collection technique needed memory reliance, it was crucial to follow the oral history method. While the study initially intended to gather lived experiences within these several social determinant contexts, it is crucial to note that while lived experiences are exclusively addressed by phenomenology, a memory driven data collection technique is dominant within oral history methodology. However these two traditions are not completely independent of each other despite the fact that research on either of the trend has rarely acknowledged the overlap. More details and support on the overlap of these two traditions are explained in the following paragraph.

According to Berg (2007), unlike the rigorous inclusion of positivists' ideals in quantitative strategy, a qualitative method contains "life-worlds [where] researchers apply naturally emerging languages and the meanings individuals assign to experience[s]" (Berg, 2007, p.14). Following Berg's analogy, therefore, this study uses oral history narratives for framing respondents' stories within symbolic interaction perspectives. Research on race and ethnicity has also emphasized collecting data on non-verbal cues that the researcher will consider while collecting data for this study.

In sociological methods, phenomenology has been critiqued by Bourdieu; however, scholars in anthropology critiqued Bourdieu's reflection on phenomenology by indicating that Bourdieu has himself used phenomenology extensively in his work (Creswell & Clark, 2011). Phenomenology has been gaining interest in nursing studies recently (Beck, 1994), as it allows researchers to get away from positivist assumptions and strengthens the objective and subjective interrelationship within the responses and across subject-researcher interactions. In this study, the phenomena studied are lived experiences of the paramedics, with a focus on specific outcomes: integration and health.

Oral history interviews are guided by the overarching phenomenology method used in this research to follow the interviewing process. Although oral history is rarely demonstrated and accepted in a large number of qualitative methods and discreetly in phenomenological as well as in oral history narrative methods that oral history is driven by phenomenological thinking, only one review found by Kenneth Kirby's(2008) is in consensus with this argument. This research observes the interrelatedness of phenomenology and oral history and supports this argument using Kenneth Kirby's review "Phenomenology and the Problems of Oral History." Nevertheless, this study realized the importance of addressing the nuance of interconnections between these two normally exclusive research method traditions.

According to Kirby, the major characteristics of phenomenology permeate the boundaries of oral history, which is a memory driven method. The "subjectivity of all knowledge, time consciousness, openness to experience, inter-subjectivity, and memory and other issues [that Kirby's study do not discuss] permeate phenomenological writing and implication for oral history are clear" (Kirby, 2008, p.23). Despite the fact that many oral history scholars use phenomenological methods and concepts, they have not described themselves as using phenomenological perspective for oral history. Based on a critical analysis of Husserl's phenomenology, Kirby (2008) argues that the many existing problems in the practice of oral history can be clarified by the use of a phenomenological standpoint.

While Kirby indicates overlap between and guiding principles flowing from phenomenology to oral history, it is however rare in the self-assessed health or nursing literature on intervention to determine oral history developing from guiding principles of phenomenology. Most likely this is because both oral history and phenomenology want to maintain their tradition by being discreet methodological processes. In this research, therefore, I address both phenomenology and oral history on the basis of differential qualities, as I have explained earlier.

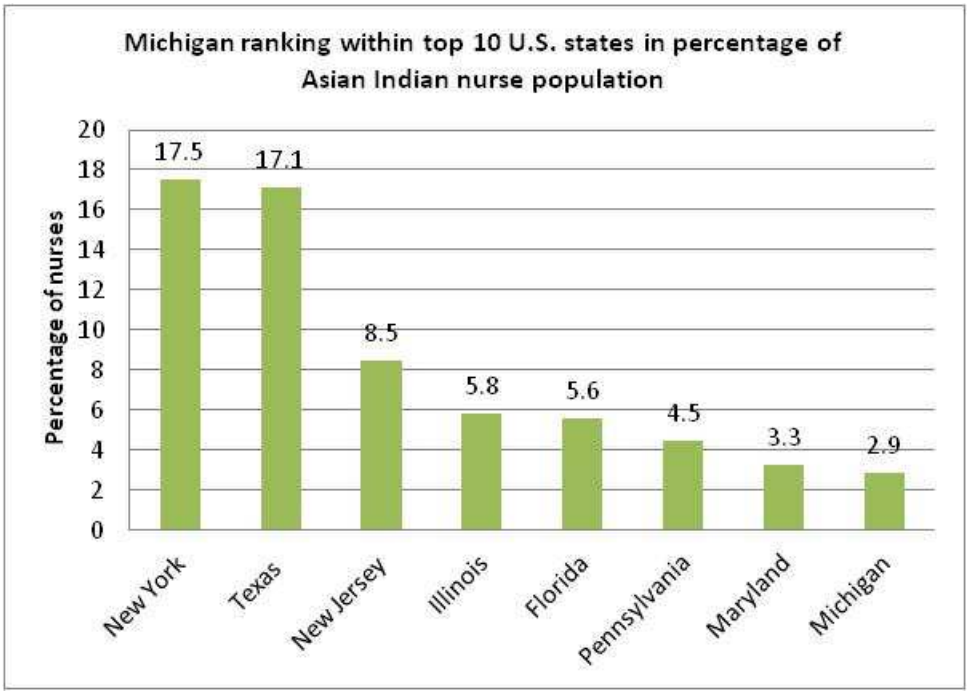
To elaborate what is oral history and its important characteristics, memory plays an important role in oral history interviews, in a sense, "oral history interviews are memory based and memories are living histories" (Portelli, 2006; Slim et al., 2006; William, 2006; Perks & Thompson, 2006). Therefore in my research, because of understanding immigrants journey as a social process in which the nuances of immigration, arrival, adaptation, assimilation and health experiences are intended to be captured, this study uses a memory-based methodological approach embodied in oral history narratives.

Qualitative data collection: Recruitment and sample

The data collection for this project was funded by the Graduate School at Michigan State University. As an initial attempt, the researcher selected a representative study population: paramedics of Asian Indian origin from within a 200 mile radius of Michigan State University. As the purpose of this study is both exploratory and interpretive to a specific population, multiple sampling strategies were applied. In the initial stage, I utilized convenience as well as purposive sampling to recruit Asian Indian paramedics. According to Mutchnic & Berg (1996), a convenience sample is the type of sample that could be easily available and chosen for appropriateness of fit. Additionally, this strategy is quick, inexpensive, and an excellent means to collect preliminary information for limited research questions (Mutchnic & Berg, 1996; Berg, 2007). My sample type was also purposive because, to select Asian Indian nurses from the population, I made a preliminary field investigation within active religious organizations of Asian Indians to seek key respondents. My sample is also snowball and criteria-based. During my preliminary investigation, I located one initial key contact, a nurse active for 15 years at Sparrow Hospital in Lansing, who introduced me to other Asian Indian health care professionals; these health care professionals are actively involved in their respective religious organizations.

A selection was made to include those individuals who have migrated and joined nursing after the 1970s in the U.S., to account for the role of global networks and globally recruiting organizations in the due process of globalization. However, not all respondents in the study migrated after 1970. In fact one participant migrated with parents as a minority and another migrated as a young adult during the peak periods of Asian migration into the U.S. during 1960s. For example, 18% of Asian Indians in the state of New York and approximately 2-3% in Michigan are nurses as is shown by the IPUMS data in **FIGURE 8**.

FIGURE 8: Michigan ranking within top 10 U.S. states in percentage of Asian Indian nurse population



Note: *The source data is obtained from Integrated Public Use of Microdata Series. The graph is produced by the researcher.*

I, overall recruited a total of 16 male and female combined nurses and physical therapists

for oral history interviews[31]. In terms of gender distribution, three respondents identified themselves as male and rest identified themselves as female[32]. The selected research sites were a combination of the East Lansing, Haslet, and greater Lansing areas. There are a number of large-sized hospitals within the East Lansing, Lansing, and greater Lansing areas, including Sparrow, Sparrow Specialty, St Lawrence, and McLaren Greater Lansing and Greater Detroit hospitals, and Ingham Regional Medical Center.

A large number of Asian Indians residing within the East Lansing, Haslett, and the greater Lansing area of Michigan enthusiastically participate in religious institutions specific to their beliefs: Indian Hindus and Jains primarily worship at Bharatiya Temple of Lansing located in Haslett; Indian Sikhs go to Gurudwara located in Lansing, and Indian Christians hold their congregation at Chapel, located within the premises of Michigan State University. My purpose for choosing religious institutions to recruit participants in is attributable to their maintenance of active and collective status through their religious institutions. Another rationale to choosing religious institutions pertains to optimizing my chances of gaining access to the population and collecting a purposive sample (Berg, 2007).

I began by collecting data by visiting religious congregations, temples and church, within the East Lansing, Lansing, Greater Lansing, and Greater Detroit areas. I made connections with temple authorities using an ethnographic approach: by utilizing my music skills and through my childhood exposure to Hinduism, I have gained access to the temple. I continued to build relationships with other members of the religious institutions by offering voluntary services and attendance, which I alternated between church and temple on weekends.

[31]The IRB clearance and interview protocol have been completed.

[32] Due to traditional gendered socialization pattern, service workers who responded to my interview are mostly female.

Mixed methods: Rationale for using quantitative methods

This study uses mixed methods for analysis, thus quantitative methods are an integral part. Quantitative research is a mode of inquiry that is used for deductive research purposes: testing a theory or hypothesis, gathering descriptive information, or examining relationships among variables (Klassen et al., 2012). Studies have illustrated the situation and context when quantitative analysis is best suited (Klassens et al., 2012; Johnson & Onwuegbuzie, 2004). This study uses quantitative methods for the following reasons, i.e., to estimate means, to establish correlations/associations, to model multiple causal paths, for generalization purposes, to allow random selection on independent variables, to assume all *a priori* cases are equally important, and most crucially, to consider the overall pattern of fit (Klassen et al., 2012).

Similarly, following Johnson and Onwuegbuzie (2004), this study uses a mixed methods approach as both qualitative and quantitative analyses bring advantages and disadvantages to data analysis, while at the same time qualitative and quantitative methods also complement each other (Mahoney & Goertz 2008). Further explanations are given in subsequent sections on the advantages and disadvantages of qualitative and quantitative methods and how to fill in gaps with a mixed methods approach.

Mixed methods: Rationale for using qualitative methods

The selection of qualitative methods for this study has multiple rationales. First, as an insider, I had personal experience, knowledge, and contact with the study population, i.e., Asian Americans of Indian origin. To gain understanding of the context that a respondent uses, a researcher's insider knowledge of the community[33] is critical to deconstruct the cues used by the

[33]It is important to note that while my insider profile eased my gaining entry into the Asian Indian community, one of the limitations of this position for me as a researcher was the constant battle to maintain a detached position

respondents[34]. While quantitative analysis is used to find particular patterns embodied within the results, qualitative analysis facilitates examining the processes underlying an action. Maxwell (1998) elucidates multiple purposes for which qualitative methods are primarily suitable for use; some of the major reasons are: (1) to understand the meanings, for the participants of the study, of the events, situations, and actions they are involved with and of the accounts that they give of their lives and experiences; (2) understanding the particular contexts in within which the individuals act, and the influences these contexts have on their actions; (3) identifying unanticipated phenomena and influences; (4) understanding the processes by which events and actions take place; and (5) developing understandings of theories for causal actions.

Shortcomings of quantitative and qualitative research

There are, of course, qualitative methods purists in the social sciences (e.g.,*see* Guba 1990), but qualitative methods are certainly not without constructive criticism (Johnson & Owenegbuzie, 2004).For example, Guba (1990), a qualitative methods purist, described how qualitative researchers adopt a strong relativist position that in itself is self-refuting. In light of this statement, literature indicates that when it comes to judging the quality of the research, no one opinion over the other is more valuable. However, the assumption is that qualitative research relies more on peoples' opinions, and that researchers are "soft relativists" (Johnson & Onwegbuzie, 2004, p. 16), respecting the views and opinions of different people. Therefore, in its entirety, qualitative research lacks a systematic standard for judging research quality (Johnson & Onwegbuzie, 2004).

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during the interview process. Maintaining a professional standing in this community, where I continue to give regular vocal music performances, was and continues to be a major challenge until I withdraw from the research site.

[34]For details See Bonilla-Silva's Color Blind Racism on making meaning out of these cues.

To optimize validity and reliability of the study, a combination of approaches and mixed methods are necessary to avoid bias in the data. In the next section, therefore, I discuss the need for using mixed methods. In addition, as contemporary social scientists increasingly adhere to post-positivist ideals in behavioral research, in this study data is accordingly presented without highlighting any definitive indicator dividing between interpretive and post-positivism paradigms. The presentations of data cut across these two paradigms because the researcher believes that although the applicability of scientific methods to research findings is crucial, a lack of understanding of multiple objectives produces a reductionist approach to social science research, which brings in the use of mixed methods.

The need for mixed methods: Qualitative and quantitative for triangulation

Berg defines triangulation as "the use of multiple lines of sight" (Berg, 2007, p.4) as a rationale for using mixed methods. Furthermore, when an event is observed directly, it is assumed that reality is deeply affected by the actions of all the involved participants. Different methods applied to observe the same event reveal slightly different facets of the same symbolic reality. For instance, if different modes of observation are combined, researchers obtain a more substantive picture of the reality, a more complete array of symbols and theoretical concepts, and a means for verifying many of these elements (Berg, 2007). According to Denzin (1970), triangulation can be divided into four categories: data, investigator, theory, and methodology. Based on Denzin's triangulation approach, this study uses both theory and method triangulation. Theory triangulation consists of "using multiple rather than simple perspectives in relation to the same set of objects," and methodological triangulation "can entail [both] within-method triangulation and between-method triangulation" (Denzin, 1970, p. 295).

Analysis of the data

The primary concern related to data reduction lies in developing a connection between theoretical constructs or concepts on the one hand, and research operations on the other (Blalock, 1982). Accordingly, in this study the measuring items for independent variables were chosen based on theoretical assumptions. For example, briefly, items for efficacy were extracted based on already established literature corresponding to efficacy instrument. Similar approach is applied in extraction of discrimination items to construct discrimination a latent variable. The dependent variable is a global measure of health acknowledged as self-assessed health. Self-assessed health in the recent years has gained reputation in social sciences. Socio-demographic variables play a major role in this research. Race and ethnicity are determined by ancestry and country of origin questions. Gender was deleted from running the model because adding gender reduced sample size from approximately 5000 to 300.

This study uses structural equation modeling to analyze data. Structural equation modeling (SEM) is a "statistical methodology that takes a confirmatory (i.e., hypothesis-testing) approach to the multivariate analysis of a structural theory bearing on some phenomenon (Byrne 1998, p.3)." Structural equation modeling represents a causal process that is based on observations of multiple variables (Bentler, 1998, cited in Byrne, 1998). There are two major components present in Structural Equation modeling, structural regression equations i.e., the causal process under study, and the pictorially modeled, which clearly indicates the theory under study (Agresti & Finlay, 1997; Byrne, 1998; Raykov & Marcoulides, 2006).

Several forms of the structural equation models are now in common use. According to Raykov and Marcoulides (2006) the commonly used SEM models are path analysis, confirmatory factor analysis, structural regression models, and the latent change model (*See*

Raykov & Marcoulides, 2006 for more detail discussion of these models). The models proposed for SEM methods is best when used based on theories, existing and proposed, that describe and explain the phenomenon that is studied (Raykov & Marcoulides, 2006). The use of SEM has gained popularity in social and behavioral sciences because of its ability to measure latent variables. Needless to say, latent variables are pervasive in social and behavioral sciences because of the particularistic nature of these disciplines. In this vein, this study is not an exception but rather contributes to latent constructs.

SEM can be used for constructing validity of instruments in measuring a latent variable, as well as for confirming and developing theories. For example, according to Raykov and Marcoulides, in a construct validation a researcher is interested in how accurately a given instrument or items measure a latent variable that they are to measure. Similarly, in this study, the utilized items were selected through the factor loadings following systematic statistical procedures, EFA and CFA. The factor loadings were run to understand if the items go together to ensure accurate measurement of construct validity of latent variables used in this study.

For instance, briefly, the construct validation question is addressed in measurement of latent variable, assimilation by efficacy and linked or common fate items. Efficacy and common fate are also latent constructs in this study. The items measuring efficacy are: QG5A: Sometimes politics and government seem so complicated that a person like me can't really understand what's going; QG5C: Public officials and politicians care what people like me think; QG5D: Public officials and politicians care what people like me think. The EFA verimax rotated factor loadings for the items are: 0.254, 0.475, and 0. 171 respectively. Eigen values for each item in efficacy are: 0.803, 0.681, and 0.541. Although it is ideal for varimax loadings to be more than 0.3 and Eigen values to be more than 1 to accept the latent measure as a factor for the given items, here strong theoretical background supports validity of these items to accurately measure efficacy (see

CHAPTER 4, TABLE 2). The common fate items are: QF2: Do you think what happens generally to other Asians in this country affects what happens in your life; QF3: Do you think what happens to other Americans affects what happens in your life.

The use of SEM is advantageous in various ways as compared to regression analysis. An important aspect of SEM is that they provide a mechanism for explicitly taking care of measurement error in observed variables for the both dependent and independent variables in the model that traditional regression analysis models fail to take into account (Agresti & Finlay, 1997; Raykov & Marcoulides, 2006). On the contrary, a traditional regression model systematically ignores potential measurement errors in the explanatory (Agresti & Finlay, 1997). Despite SEM as a more advanced statistical analysis that demands more interactive process between the researcher and theoretical model building process, this method is used for both direct and indirect model estimation; an advantage of reaping the benefits of SEM's sophistication technique over regression model. The following paragraph will illustrate this argument in more detail.

The process is interactive because to reap utmost advantage from SEM and its sophistication technique in model building, SEM demands greater involvement of the researcher in locating unknown model parameters. It is recommended that prior to running the analyses in SEM, researchers should tally the number of parameters in the model to be estimated (Byrne 1998). Failing to do this correctly can lead to finding no unique estimation of the model under study (Raykov & Marcoulides, 2006). This demonstrates how SEM is an interactive process. For further clarification I provide and highlight an illustration provided by Raykov and Marcoulides (2006) that compares SEM with a regression model. The image captures in more details how SEM possesses more interactive characteristics as compared to a regression model. Raykov and Marcoulides (2006) indicate that in an attempt to fit a regression model with one dependent

variable and three independent variables and an error with any major statistical package, such as SPSS or SAS, can start out as an unidentifiable statistical run because regression analysis follows only one possible path to estimate the unknown parameters. In the regression analysis method, a researcher only needs to specify dependent and independent variables and by default software determines the model parameters (Raykov & Marcoulides, 2006). This procedure is primitive and does not take into account a researcher's ability to specify a model that is usually generated on the basis on theoretical understanding. As illustrated, this comparison clearly indicates a researchers' advantage and advancement in the similar vein that SEM validates itself as an interactive statistical estimation method advanced and nuanced over regression analysis. Because of its advance mechanisms, SEM can readily and effectively test a model involving both direct and indirect effects of the variables. On the contrary, regression analysis has the ability to estimate indirect effects by means of a complicated process. However, this will be only possible when there are no measurement errors in the used predictor variables, which is an unrealistic case to attain due to complexity of social and behavioral sciences (Agresti & Finlay, 1997; Raykov & Marcoulides, 2006). To further illustrate the meaning of direct and indirect effect I draw examples from this study.

In this study, SEM is used for estimating both the direct relationships between the independent variables and dependent variable (health outcomes) and the moderation effect of assimilation and discrimination on the direct relationship between several independent variables and the dependent variable (health outcomes). Here, by direct relationship I mean the relationship between independent variables and the dependent variable without any influence of mediation and moderation effect assumed in the model estimation understood as indirect relationship between moderators and independent variables used in the model to hypothesize the relationship between and among variables. EFA assumes that the variables are free of error

terms, unlike the same assumption that the SEM mechanism enables. Based on its appropriateness in this study, to test the statistical significance, Structural Equation Modeling (SEM) will be used. In sum, SEM allows testing of regression equations while simultaneously distributing the error terms unlike any other regression analysis or SEM specifications. As SEM can also handle the most basic direct effect relationships between variables with appropriately specified unknown estimators by the researchers, following SEM provides optimum credit to researcher as well in relation to, but not limited to, model specifications.

According to Raykov and Marcoulides (2006), several computer programs are available to compute SEM analysis. AMOS, EQS, LISREL, Mplus, SAS, PROC CALIS, SEPATH, and RAMONA are the once listed by Raykov and Marcoulides (2006) based on the assumption that their contribution will evolve yet in further development in application in SEM methodology. They claim that although all of these listed SEM software have measurably similar capabilities, LISREL and EQS seems to have dominated the field from the past for a substantive amount of time (See Raykov & Marcoulides, 2006; Marsh, Balla, & Hau, 1998). More recently, M-plus has gained greater acceptance among social, behavioral, and educational researchers. In contrast, with other software of similar lineage, Mplus uses WLMV. Quantitative data was commonly analyzed using SPSS and Mplus, although the test of the hypothesized model is simultaneously analyzed along with the entire system of variables to determine the degree of model fit with the data (Byrne, 1998). Based on a comparison between command files used in EQS, LISREL and Mplus for the analysis of structural regression model, Raykov and Marcoulides (2006) find that between these three popularly used programs for the analysis of SEM, Mplus utilizes minimum strands of commands; hence, it is economical in processing commands and by default sets parameter constraints. This is another essential feature in considering model identification (See

Byrne 1997; Raykov & Marcoulides 2006, p.151 for more details) that is absent from EQS and LISREL.

For this study the use of Mplus carries another important reason. Usually, SEM assumes that dependent variables are continuous and measured on an interval scale (Tabachnick & Fidell, 2007, p. 729). In my dissertation, the measured variables are categorical. The most helpful SEM program for models with categorical data is Mplus (Tabachnick & Fidell, 2007; Muthen & Muthen, 2004). To estimate categorical variables, Mplus uses weighted least squares mean variance, (WLSMV) which is integrated in Mplus by default. On the contrary, the use of categorical variables in SEM is handled by a conversion procedure for analysis by other SEM programs, such as LISREL or PRELIS (Tabachnick & Fidell, 2007). Additionally, given that this is a phenomenological study that uses oral history narratives, the qualitative data will be used verbatim to support and strengthen any findings from quantitative data analysis.

In qualitative data analysis, the raw data was transcribed. During interview the oral histories were recorded with respondents' permission and were transcribed. All respondents were comfortable speaking in English. Whenever a Hindi or other Indian languages were used, researcher transcribed them in English. As the questionnaire was designed by themes, the transcription automatically developed in accordance with the thematic pattern. No coding was necessary. The interview data gathered was used verbatim.

Unit of analysis

Based on the conceptual model, I chose several observed variables pertaining to different levels of measurement. At the individual level, social psychological concepts were used to select attitude items. Following Massey and colleagues (1993), my analysis of the data on the adaptation of Asian Indian nurses and therapists in the U.S. is conceived as multilevel and spiral.

Different levels of analysis do not operate in isolation; instead they are dialectical. Each level influences the other in any resulting outcome of a social process. Similarly, again following Massey and colleagues, migration is set within the web of linkages between transnational borders, and extends a process that evolves through the three overarching levels of analysis: macro, meso, and micro. For the purpose of this study, further disintegration of these three levels has been designed to develop measurable units: individuals, families, ethnic groups, and institutions. The social, economic, and political changes occurring at the global level intersects with the meso (family and ethnic belonging) and micro (individual) levels to complement the process of immigrants' entry, adaptation and health outcomes. The unit of analysis in this study, however, will be the individual, through the use of narratives collected from Asian Indians. According to (Miles, Huberman, & Saldana, 2013), data analysis generally can be divided into three concomitant acts: data reduction, data display, and conclusions and verification (Also *see* Levin 1985 cited in Berg & Lune, 2004).

CHAPTER 4

QUANTITATIVE RESULTS

Introduction

In this study I investigated the influence of social determinants on self-assessed health outcomes among immigrants of Asian origin. In addition, this study also examines moderator effects of assimilation and discrimination on the influence of multiple social factors on health outcomes. In this chapter, I will report the findings from quantitative analysis. The data is analyzed using structural equation modeling (SEM). As described in the literature

> "model testing using SEM, is to test the goodness of fit of one or more hypothesized model. These hypothesized models present hypothesized relations between constructs (latent variables) and their observed variables (those that are measured) that serve as indicators of those constructs" (Nicol & Pexman, 2013, p. 133).

I use exploratory and confirmatory factor analyses (EFA and CFA) to understand the magnitude of factor loadings on *m* dimensions when theoretical support is not established for a measure, and application is deemed useful for an item. As the exploratory factor analysis is not the primary focus of this study, therefore, briefly, exploratory factor analysis is used to search for an appropriate value for *m* factor(s) in m-dimensions, where factors are also sometimes referred to as latent variable. The factors were selected for exploratory factor analysis based on the researcher's understanding that the selected factors will explain relationships among the observed variables adequately (Agresti &Finlay, 1997). The factors were selected to maximize the explanatory power by inspecting the correlation among observed variables. I started this process with clustering the variables that presumed to correlate. The strongly correlated or variable clusters, with high loadings represent a factor. The EFA results hence provide data

driven rather than theory driven assumptions to cluster variables into factors. The reliability and validity of the assumed linear relationship between the observed variables and latent variables used in this study are tested using both factor loadings and Eigenvalues. The theoretically robust items were used because of their greater reliability and validity. The reliability and validity are presented in the table supported by the specific theoretical references (see **TABLE 2** and **TABLE 3**). In addition, Alpha values are also provided to establish validity and reliability of the instruments used in this study. Beside theoretical support, confirmatory factor analysis (CFA) was carried out to check whether a particular a-priori choice of *m* number of factors matched the robustness of theoretically supported clustering of a set of items to respond adequately to the construct validity. The CFA is a more structured analysis compared to EFA. The observed variables selected to load on a factor for the analysis of CFA are based on robust theoretical validity. Contrary to the use of CFA, which is more structured, EFA is more exploratory in nature and does not take theoretical support for the clusters of highly loaded set of observed variables on factors.

While descriptive statistics, Coefficient alpha, and correlations of the variables are analyzed using statistical software SPSS, latent variable modeling, EFA, CFA and Structural Equation Modeling are analyzed using Mplus. Sample statistics were also extracted using Mplus. This research uses normal theory-based maximum likelihood (ML) estimator. ML estimator is known for its consistency, normality and efficiency in model estimation (Bollen, 1989). However, for ordinal-scaled observed variables, more robust WLSMV (Muthén, Du Toit, & Spisic, 1997; Muthén & Muthén, 2008) have been proposed in the literature; Mplus is equipped with generating robust least square estimator for ordinal variable with correction[35]. In all together

[35] SEM assumes continuous measured variable and generates a covariance matrix. The researcher tries to reduce the gap between observed data and hypothesized model with goodness – of – fit index. However, when outcome

both maximum likelihood and weighted least square means variation (WLSMV) estimations are used in this study to estimate models. The maximum likelihood is used to find the "best linear combination of predictors to maximize the likelihood of obtaining the observed outcomes frequencies" (Tabachnick & Fidell, 2007: p.439).

According to Tabachnick and Fidell (2007) maximum likelihood is an iterative procedure that starts with arbitrary values of coefficients for the set of predictors and determines the direction and size of change in the coefficients that will maximize the likely hood of obtaining the observed frequencies. In the next step, residuals for the predictive model based on those coefficients are tested and another determination of direction and size of change in coefficients is made until the coefficients change very little. In the results section, I will describe the construct validity of measurement model to answer the first research question. Next, I will report findings from full model and moderation effects. Results for the measurement model are illustrated in **TABLE 4** and rest of the models will be reported following this table.

Results

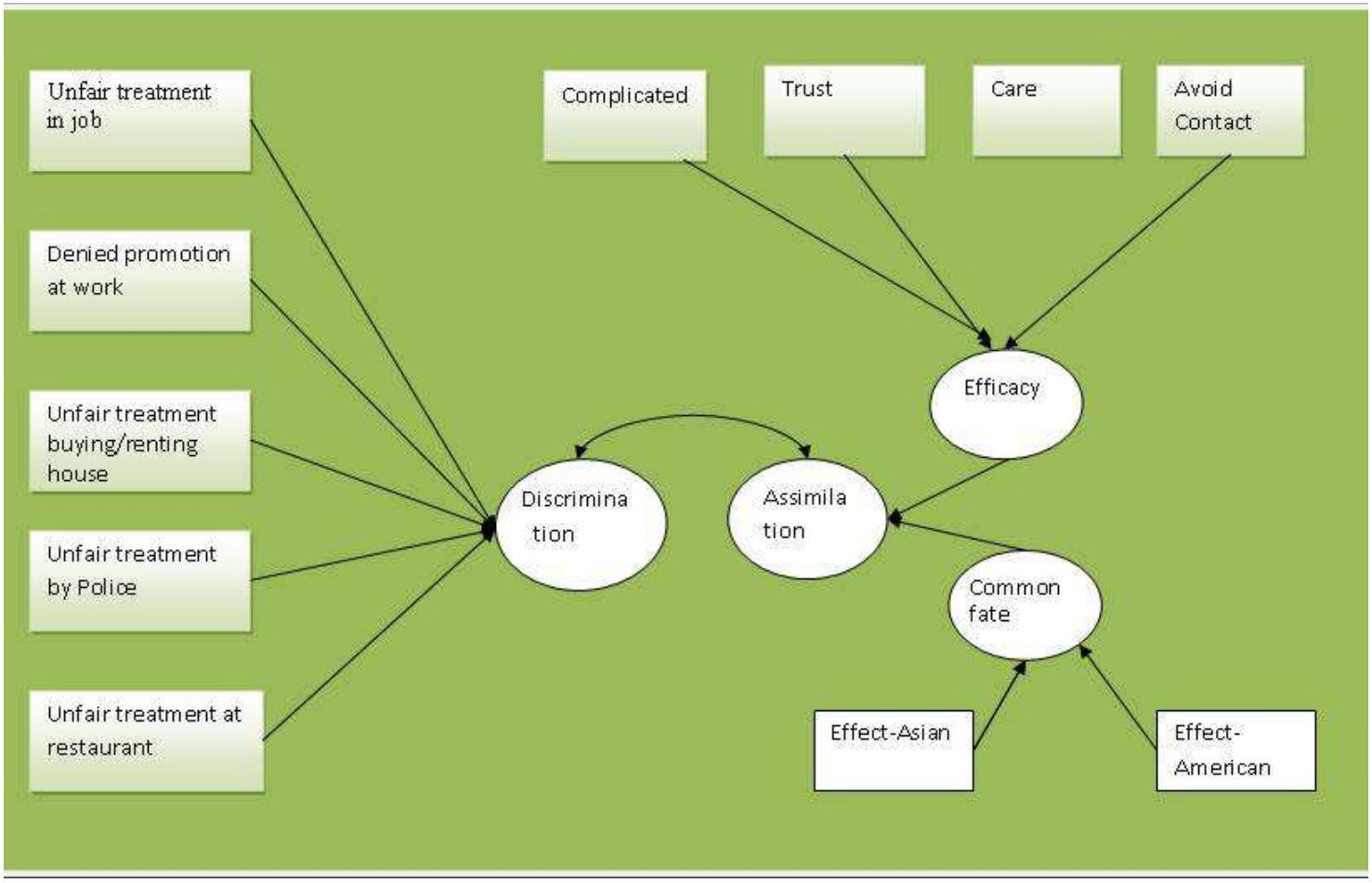
All respondents, N=5,159 included in the survey were 18 years and older, a greater number are male than female and largely of Asian origin by birth (**TABLE 2**).A confirmatory factor analysis (CFA), based on the data from NAAS 2008, was performed through M-plus on four sub-sets of the social and political attitude. The hypothesized model is presented in **FIGURE 9**. In accordance to the norm of representing CFA models, the circles represent latent variables and rectangles represent observed variables. A higher order model of discrimination and assimilation is hypothesized. The absence of direct lines connecting variables indicates no

variable is ordinal or categorical, correlation matrix is generated. In this situation WLMV is the ideal estimator that is handled more efficiently by Mplus.

hypothesized direct relationship. The observed variables are: QG5_A (the politics so complicated cannot understand what is going on); QG5_B (We can trust our government in Washington to do what is right); QG5_C (Public officials and politicians care what people like me think); QG5_D (People are better off avoiding contact with government) are loaded on efficacy factor (*See* Table 2 for details). The QF2A_1 is an observed variable recoded using two other observed variables, QF2 (What happens to other Asians affects your life?) and QF2A (Will it affect you a lot, some, or not very much?). The variable QF3A_1 is another observed variable re-coded using QF3 (What happens to other [R Ethnic Group] Americans affects your life?) and QF3A (Will it affect you a lot, some, or not very much?) and loaded on common fate factor. Both factors, common-fate and efficacy, were loaded on latent variable assimilation. Because of 90% missing data on the items measuring discrimination among native born, it was dropped from the analysis and the measurement model.

The items loaded on discrimination factor, as illustrated in **TABLE 3**, are clustered by nativity; both foreign born and U.S. born participants were asked same questions for the construction of the discrimination scale. However, for this study only foreign born population is used. The variable discrimination labeled as DISCRIM, used in analyzing the moderation effect and added in the moderation model. The items used to measure discrimination are as follows (see **TABLE 3**): QF5_A (Ever been unfairly denied a job or fired?), QF5_B (Foreign Born and Native Born) (Ever been unfairly denied a promotion at work?) QF5_C, (FB) (Ever been unfairly treated by the police?), QF5_D (FB) (Ever been unfairly prevented from renting or buying house?) and QF5_E (FB) (Ever been treated unfairly or badly at restaurants or stores?) The two factors, discrimination and assimilation, are co variances in the models.

FIGURE 9: Measurement model of assimilation, discrimination, efficacy, and common-fate



Model estimation: Measurement model

The null hypothesis tested in this model is that there is no difference between the pattern observed in the data and the model specified. The model hypothesis was examined using statistical soft ware Mplus. Mplus uses list wise deletion technique to process missing data (Muthen & Muthen, 2009). The sample size is 5,145 after a *LISTWISE* deletion of 219 missing data; all missing cases were set as missing. It is a single-group modeling with 11 independent variables and 4 continuous latent variables. The estimator used for this model is WLSMV and the model estimation terminated with 1000 iterations, which is maximum number of default iteration in Mplus. Based on Chi-square (χ^2)-value, χ^2 test of model fit = 265.899* at degrees of freedom=41 (P-value= 0.000), the model estimate is different from the data and rejects the good-model fit hypothesis. Model χ^2 statistics, however, is highly sensitive to sample size, and should not be used as a sole reason to reject a null (Wang & Wang, 2012). The RMSEA (Root Mean Square Error of Approximation), estimate = 0.033 is <.05 at 90 percent C.I (0.029 0.036), indicating a good-to-moderate model fit and is inconsistent with the Chi-square findings for this model. Both CFI and TLI values are consistent with good model fit outcomes: CFI = 0.981and TLI = 0.974. **TABLE 4** shows the goodness of fit for the confirmatory factor analysis for the measurement model of assimilation by using efficacy and common fate.

TABLE 2: Reliability and validity of efficacy and common fate

Assimilation			
Subscales	***Items***	***Reliability and Validity***	***Eigenvalues***
Efficacy	Sometime political and government seem so complicated that a person like me can't understand what is going on	**Theoretical validity:** (*See* Craig, Niemi, and Silver 1990; Niemi, Craig, and Mattei, 1991; Morrell, M, 2003). Cronbach Alpha=.050	**1.659**
	People can trust government in Washington		**1.542**
	Public Officials and politicians care what people like me think		**1.083**
	People are better off avoiding contact with government		**1.002**
Common fate	Do you think what happens to other Asians in this country affects in your life.	**Theoretical validity:** (Yoder,Snell & Tobias, 2012; Bedolla, 2012; Bedolla, 2006 found reliability >.75; Ramakrishnan et al., (2008); NAAS 2008; Junn and Masuoka (2008); Sanchez and Masuoka (2010). Cronbach Alpha=.773	
	Do you think what happens to other (ethnic)Americans affects a lot, some mot very much and none to what happens to your life		

TABLE 3: Reliability and validity of discrimination

Discrimination	
Items	***Reliability and Validity***
(FB) Ever been unfairly denied a job or fired?	**Theoretical validity**:(*See* Utsey & Ponterotto, 1996) Cronbach alpha = .595
(FB) Ever been unfairly denied a promotion at work?	
(FB) Ever been unfairly treated by the police?	
(FB) Ever been unfairly prevented from renting or buying house?	
(FB) Ever been treated unfairly or badly at restaurants or stores?	

Note: *Foreign Born (FB) sample used to measure discrimination factor. The everyday discriminations are more covert to be easily distinguished by the victims (See Utsey & Ponterotto, 1996 for more details on discrimination scales)*

TABLE 4: Measurement model: Assimilation, discrimination, efficacy and common fate

Model							
Latent/Explanatory Variables	Un-stand. Loadings	Est/S.E. Z-value	Standard. Loadings	Standard Est/S.E.	R^2	Residual Variance	
Efficacy							
Can't understand politics	1.000 (.000)	999.000	0.209 (0.021)	9.918	.043*** (0.957)	0.957	
Trust in Govt.	3.358 *** (0.043)	7.585	.700*** (.043)	16.355	.490*** (0.510)	0.510	
Care for people	2.172 *** (0.235)	9.260	.453*** (.029)	15.733	.205*** (0.795)	0.795	
Better to avoid contact with Govt.	0.813*** (0.122)	6.681	.170*** (.021)	7.912	.029*** (0.971)	0.971	
Comm. fate							
effected by Asians (in-group)	1.000 (0.000)	999.000	0.926*** (0.042)	22.277	.857*** (0.143)	0.143	
effected by Americans (Out-group)	0.894*** (0.080)	11.139	0.827*** (0.038)	22.005	.684*** (0.316)	0.316	
Discrimination							
At job	1.000*** (0.00)	999.0	0.795*** (.022)	35.333	0.632*** (0.368)	0.368	
Job promotion	1.020*** (0.044)	23.384	0.811 *** (.020)	39.719	0.657*** (0.033)	0.343	
By police	0.807*** (0.038)	21.222	0.642 *** (.025)	25.744	0.412*** (0.032)	0.588	
Renting or buying house	0.723*** (0.046)	15.699	0.574 *** (.034)	17.139	0.330*** (0.038)	0.670	
Restaurant or Store	0.774*** (0.037)	21.102	0.615*** (.024)	25.684	0.378*** (0.029)	0.622	
Assimilation *Efficacy	1.000*** (0.000)	999.0	0.310 *** (.049)	6.380			
Assimilation *Common fate	4.111*** (0.756)	5.435	0.287 *** (.043)	6.629			
Discrimination w/assimilation (cov)	0.045*** (0.007)	6.351	0.876 *** (.124)	7.062			
Discrimination(Variance)	0.632 (0.036)	17.667	1.000 (0.00)	999.00			
Assimilation (Variance)	0.004* (0.002)	2.624	1.000 (0.00)	999.00			
Efficacy (Res. Variance)	0.039 (0.008)	4.933	0.904*** (0.030)	30.033			
Comm. Fate (Res. Variance)	0.787 (0.075)	10.426	0.0918*** (0.025)	36.942			
R^2 Efficacy					0.096** (0.030)		
R^2 Common fate					0.082** (0.025)		
$\chi 2$ = 265.899* df=41, p-value 0.000							
CFI = 0.981 TLI= 0.974 WRMR =1.707							
RMSEA =0.033, 90% C.I.(0.029 - 0.036) P RMSEA<=.05 1.000							

Note: N=5145; ***p <.001; **p<0.01; *p<0.05; S.E are in parenthesis.

Model estimation: Full model

In the second step of the data analysis, assimilation and discrimination was added to test the null hypothesis: discrimination has no effect on self-assessed physical health outcomes among people of Asian descents living in the U.S. The model was run simultaneously with discrimination and assimilation after adding other independent variables hypothesized in the model: socioeconomic status, socialization, civic engagement, religiosity, assimilation, and discrimination. The socio-demographics, gender, race and ethnicity are controlled[36] in the analysis. The variables which had non-significant effect were removed in steps. The outcomes are reported in the **TABLE 5**, which reports the final findings for the full model. The zero order correlation tables are reported in tables (**TABLE 9, TABLE 10, TABLE 11**)

[36] According to Macintyre, Maciver and Sooman (1993), in public health literature, the concept of control is to "explain away" if any relationships exist between cause and condition or predictor and outcome. However, in crucial circumstances, statistical verification of "explain away" concept is not deemed essential and the effect of "controlled" variables are consciously repeated in some studies to emphasize analytical and policy interests (See Macintyre, Maciver, Sooman, 1993 for details.

TABLE 5: Structural/full model estimates of assimilation, discrimination and self-assessed health outcomes

QG2: Dependent variable (How will you rate your overall physical health)			
Latent/Explanatory variables	***Un-standardized Estimates***	***Est./S.E***	***p-value***
Assimilation	-3.330 (4.112)	-0.810	0.418
Discrimination	0.215 (0.933)	0.230	0.351
Discrimination (cov)Assimilation (cov)	0.034 (4.416)	0.008	0.000
	Standardized Estimate	***Est./S.E***	***p-value***
Assimilation	-0.164 (0.183)	0.895	0.371
Discrimination	0.154 (0.165)	0.933	0.351
Discrimination (cov) Assimilation (Cov)	0.786 (0.144)	5.447	0.000

TABLE 5A: Structural/full model estimates of assimilation, discrimination, social determinants and self-assessed health outcomes

QG2 (How would you rate Self-assessed health?) (Dependent Variable) Latent/Explanatory Variables	Estimates	Est/S.E. Z-value	Standardized Estimates	Standard Est/S.E.	R^2	Variances	Residual variance
QC14_D1: family Socialization	0.041 (0.042)	0.976	0.018 (0.018)	0.976			
QH2 : Religious Attendance	-0.015 (0.013)	-1.127	-0.021 (0.019)	-1.127			
QG_1: Financial Status	0.122*** (0.020)	6.015	0.107*** (0.018)	6.063			
QC18 : Civic Engagement in migration march	-0.421** (0.150)	-2.809	-0.041** (0.015)	-2.812			
QC19_2: Civic engagement country politics	-0.243* (0.097)	-2.517	-0.044*** (0.017)	-2.517			
QJ2: U.S. Specific Education	-0.318*** (0.045)	-7.088	-0.126 (0.018)	-7.156			
QS2_D1 Self race /ethnicity (Asian=1)	-0.057 (0.151)	-0.376	-0.015 (0.040)	-0.376			
QS2_D2 Self race /ethnicity (Chinese=1)	0.046 (0.114)	0.405	0.015 (0.038)	0.405			
QS2_D3 Self race /ethnicity (Indian=1)	-0.457** (0.155)	-2.940	-0.138*** (0.047)	-2.946			
QS2_D4 Self race /ethnicity (Filipino=1)	0.463** (0.144)	3.222	0.155*** (0.048)	3.231			
QS2_D6 Self race /ethnicity (Jap=1)	-0.085 (0.194)	-0.440	-0.014 (0.032)	-0.440			

TABLE 5A (Cont'd)

QS2_D7: Asian American vs. Others	0.238*** (0.079)	3.011	0.096*** (0.032)	3.016			
QA1_D1: Chinese Ancestry vs. Others	0.313*** (0.131)	2.392	0.096*** (0.040)	2.394			
QA1_D2: Indian Ancestry vs. Others	0.877*** (0.094)	9.331	0.348*** (0.036)	9.565			
QA1_D3: Filipino Ancestry vs. Others	0.856*** (0.140)	6.098	0.277*** (0.045)	6.149			
QA1_D4: Vietnamese Ancestry Vs. Others	-0.356** (0.129)	-2.759	-0.128** (0.046)	-2.766			
QA1_D5: Korean Ancestry vs. Others	0.616*** (0.074)	4.721	0.142 *** (0.030)	4.724			
QG5_A Politics so complicated					0.035		
QG5_B Can trust our government					0.365		
QG5_CPublic official care					0.235		
QG5_D better to avoid contact with govt.					0.034		
QF5_A discrim at job					0.622		
QF5_B discrimination at work					0.665		
QF5_C discrimination in buying house					0.387		
QF5_D discrimination in					0.318		
QF5_E unfair treatment at restaurant					0.346		
QF2A_1in-group fate					0.799		
QF3A_1out-group fate					0.706		
QG2 Self-assessed physical health (dependent var)					0.189		
Latent Variables							
Efficacy					0.098	1.000	0.902
Commonfate					0.098	1.000	0.902
X^2 Value = 607.075* Degrees of Freedom 270 P-Value 0.0000							
CFI 0.940 TLI 0.932							
RMSEA = 0.020< .05 WRMR = 1.493							
;							

N= 3216; ***p <.001; **p<0.01; *p<0.05; Dependent variable: Self-assessed health outcomes

The goodness of model fit indexes are: χ^2 (N = 3216) = 607.075; Degrees of Freedom 129; P-value = 0.0000. It is noted that χ^2 value is sensitive to the sample size. Large sample tend to provide a significant χ^2. This is a primary reason why χ^2 is significant. The other fit indexes, RMSEA = 0.020, which is < .05; CFI = 0.940; TLI = 0.923; WRMR = 1.493. Other than χ^2 value, goodness of fit indexes show that there is sufficient-to-moderate evidence to not to reject the null that model fits the data. The findings are presented in **TABLE 5A** (continuation of the main **TABLE 5**)

The full model findings show that both assimilation and discrimination have no effect on the outcomes of self-assessed health among immigrants of Asian origin. The analysis of data in this model pertained to foreign-born Asians. Due to a 90% of the cases missing in native born Asian sample, the discrimination variables (five questions on discrimination) for native born was dropped in this analysis of model-fit. In the final estimation of full model, discrimination experiences added are of foreign born only. Within the race and ethnic group i.e., respondents of Asian ancestry with >600 (Asian American overall, Chinese, Indian, Filipino, Vietnamese and Korean) has significant effect on self-assessed health outcomes. In addition to this, for the minorities of Vietnamese origin, there is significant evidence in the data that a negative relationship exists between Vietnamese origin and self-assessed physical health outcomes. To illustrate further, among all Asian origins, people of Vietnamese origin are more likely to have poor health outcomes. The reason behind this and other findings will be explained in the discussion section.

Controlling for race and ethnic characteristics, among all social determinants included in the full model, i.e., socializing and spending more time with family and friends rather than at work, attending place of worship with a maximum frequency of every week, participating in activism and civic amelioration, such as immigration marches of 2006 and contributing to politics of the country of origin, financial status in the year 2008, and all educational attainment were from the U.S., the variables with significant effect on self-assessed health outcomes are noted below. The financial status of the respondents in the year 2008 (the survey year) indicating that they are better off this year compared to last year predicts their self-rated health outcomes positively significant after controlling for race and ethnicity. It is, however, noteworthy that the magnitude of the increase remains small because with the increase in

financial status every year the health condition increases by 12.2 % controlling for race and ethnicity (**TABLE 5**).

The participation in activism such as in immigration marches of 2006 in the U.S. and taking part in political affairs of the country of origin although show statistically significant effect over self-rated health outcomes, the relationship has negative effect on health. Both variables: "participation in immigration march" and "taking part in political affairs of the country of origin" are coded as 1= Yes and 2= No. Keeping in line with the original data coding, the findings for civic engagement indicates that those who tend to stay engaged civically such as in immigration marches and country of origin politics are less likely to experience poor health outcomes. This finding is concurrent with the literature and indicates similar results of the relationship civic engagement and self-assessed health.

Similarly, contrary to the previous findings frequency of religious attendance and its benefits on health, a vast number of studies indicated that frequent religious attendance is beneficial to health. Contrary to the findings from previous research, my findings show that religious attendance is non-significant with a small negative value by 0.1% standard unit. As was expected, however, U.S. specific education overwhelmingly and positively predicts outcomes of self-rated health among Asians. Although the direction of the finding indicated is negative, yet again going back to the original coding of the variable indicates that respondents who replied "Yes' to U.S. specific education are coded = 1 and rest are coded as No=2. Statistically this relationship can be restated as with every change in the level of education gained in the U.S self-rated health outcomes will get better by 33.4 %. After adding more race, ethnic and other demographic variables, such as Japanese ancestry and employment status, as controls**(TABLE 6)** the significant influence of the social determinants do not show noticeable

variation from the model presented in **TABLE 5**. The variance explained by efficacy items (Complicated, trust, care, contact) R^2=3.5%, 36.5%, 23.5%, 3.4% respectively. Similarly, variance: R^2 explained by other independent variables and dependent variables included in the model are listed in **TABLE7**.

TABLE 6: Structural/full model estimates of social determinants and self-assessed health outcomes

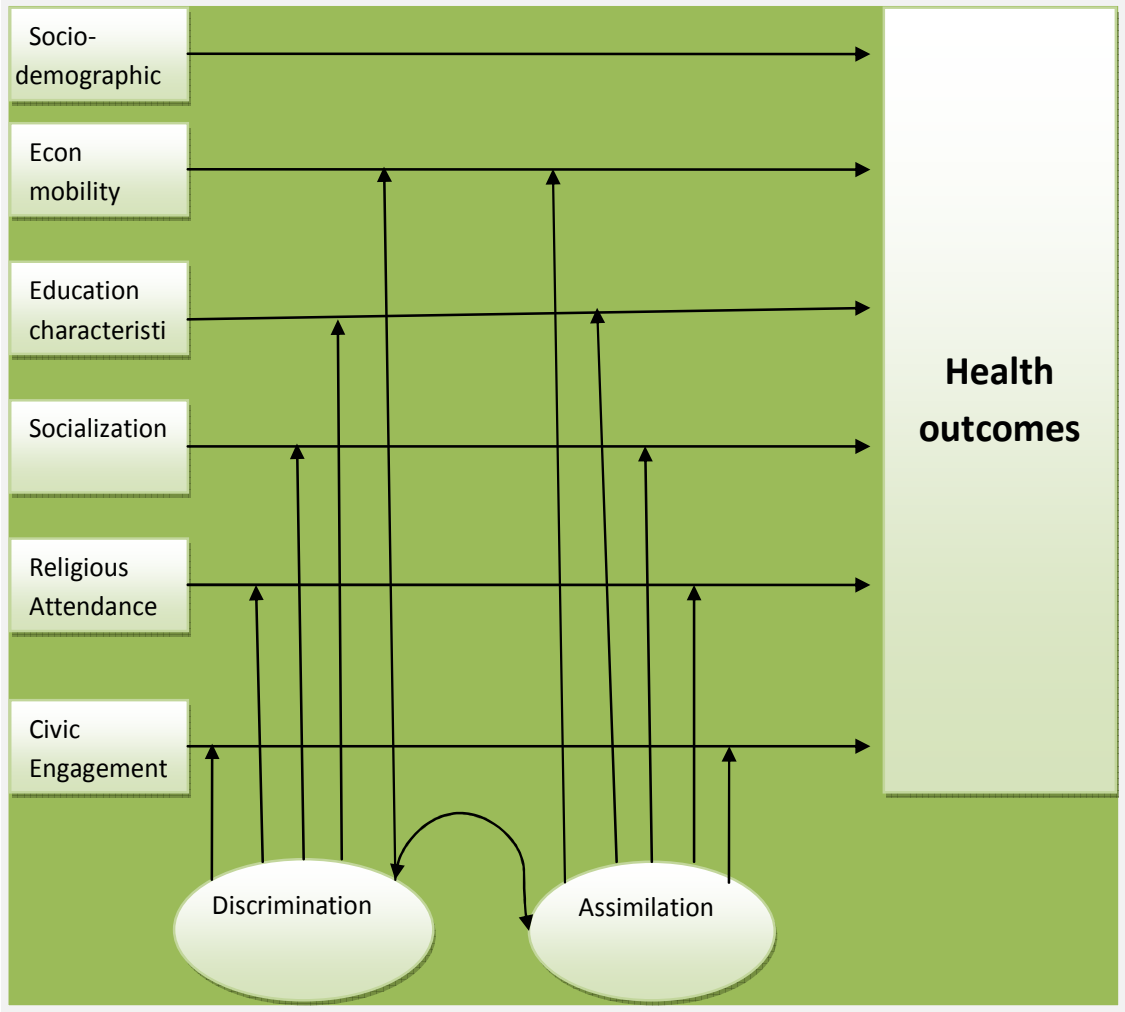
Variable	Unstandardized Estimate (S.E.)	Std. Estimate
EFFICACY BY		
QG5_A politics complicated	1*** (0)	0.173
QG5_B we can trust our government	3.673*** (0.71)	0.636
QG5_C public officials cares what we think	2.724*** (0.47)	0.471
QG5_D better off avoiding govt.	1.09*** (0.219)	0.189
QF5_A Unfair treatment at job	1*** (0)	0.804
QF5_B Unfair with promotion	1.015*** (0.061)	0.816
QF5_C unfairly treated by police	0.751*** (0.049)	0.604
QF5_D unfairly treated in buying/renting house	0.689*** (0.058)	0.554
QF5_E unfairly treated at restaurants and stores	0.707*** (0.046)	0.569
QF2A_1 What happens to other Asians effects	1*** (0)	0.898
QF3A_1 What happens to other Americans affects	0.928*** (0.116)	0.838
Efficacy	1***(0)	0.303
Common Fate	5.825*** (1.609)	0.340
QG2 Self-assessed health outcome ON		
Assimilation	-0.943 (2.134)	-0.044
Discrimination	0.113 (0.109)	-0.081
QC14_D1: Family Socialization	0.019 (0.04)	0.008
QH2 Religious Attendance	-0.004 (0.012)	-0.005
QG_1 Financial Status	0.126*** (0.02)	0.109
QC18 Civic Engagement in migration march	-0.366* (0.153)	-0.035
QC19_2 Civic engagement country politics	-0.201* (0.097)	-0.035
DISCRIM WITH ASSIMI	0.029*** (0.007)	0.699

Note. N= 3216; ***p <.001; **p<0.01; *p<0.05; $\chi 2 = 345.005$, df =110, p < 0.001; CFI= 935, TLI= 923, RMSEA=0.026, WRMR=1.560

TABLE 7: Effect size (R^2) and residual variance of the measures in full model

Variable	R^2	Residual Variance
QG5_A Politics complicated can't understand	0.03	0.97
QG5_B Can trust government	0.404	0.596
QG5_C Government care	0.222	0.778
QG5_D Avoid contact with government	0.036	0.964
QF5_A discrim at job	0.646	0.354
QF5_B discrimination at work	0.665	0.335
QF5_C discrimination in buying house	0.365	0.635
QF5_D discrimination by police	0.307	0.693
QF5_E unfair treatment at restaurant	0.324	0.676
QF2A_1in-group fate	0.807	0.193
QF3A_1out-group fate	0.694	0.306
QG2 Self-assessed physical health (dependent var)	0.209	0.996
Latent Variables		
EFFICACY	0.092	0.908
COMMONF	0.115	0.885

FIGURE 10: Structural/moderation effect of assimilation and discrimination on the relationship between social determinants and self-assessed health outcomes[37]



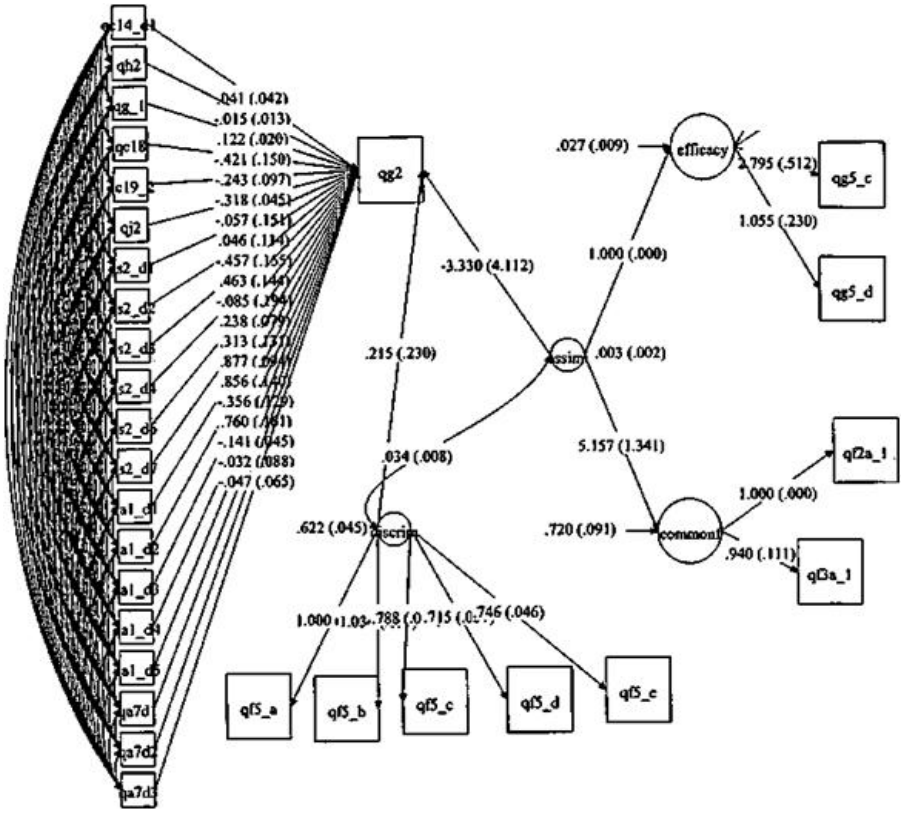
Model estimation: Moderation effect of assimilation and discrimination

All the demographic variables included in full model are not controlled in the moderation model. The hypothesized interaction effect model of assimilation and discrimination fits the data (see **FIGURE 10**; **FIGURE 12**; **TABLE 8**). However, assimilation, discrimination, and other social measures used are found to have non-significant effect on the self-assessed health

[37] This interaction model diagram represents a generalized model. Also, for comprehension purpose, this diagram provides a visual representation of the interaction effects. Not all interaction effects shown in the diagram were added in the analysis. More accurate understanding of which interaction effects were included in the actual analysis, *see* Table 5

outcomes. In other words there is no effect on self-assessed health outcomes regardless of Asian immigrants' assimilation or experiences of discrimination.

FIGURE 11: Mplus generated structural/full model estimates of the study



In this model socialization with work was added in addition to variables present in the full model. The findings show that effect of none of the social determinants is exclusive of assimilation and discrimination in the moderation model. In other words, the effects of social determinants on the outcomes of health among Asian does not depend on assimilation and discrimination outcomes. The **FIGURE 13** presents the measurement, structural/full and moderation model all combined in one framework.

A special case: Is Asian health a paradox?

After having the findings by analyzing the broader models (measurement model, full model and moderation model), as illustrated in the introduction chapter, this study also explores and describes if there is Asian health paradox. This investigation involved step wise data analysis process and treated as a special case of broader model testing constituting both measurement and full model fits, with direct and moderation effects, indicating relationship between various potential social determinants and outcomes of health. While the broader model test indicated the relationships between predictors and dependent variable, in the context of discrimination, this study investigates whether discrimination exists among the surveyed population. As this data set does not allow across group test to examine the special case, Asians as paradox, the next step followed a one sample T-test, which is conducted on different measures/items of discrimination.

The T-test of significance also serves the purpose of suppression of the ideal case where non-White Hispanic population is considered as frame of reference. For this T-test the total sample used is 5,159. There were five discrimination items (**TABLE 3**) each coded No= 0 and Yes=1. The composite item of discrimination was created by averaging the five items which can range from 0 to 1. For each respondent an average of 0 means there was no discrimination experienced in any of the five cases. An average of 1 means the person experienced discrimination in at least one of the five cases. The composite average of discrimination with the five items combined =.1248. The null hypothesis (H_{t0}) tested states: discrimination (mean) = 0. The alternative (H_{t1}) hypothesis is: discrimination (mean)> 0. The one sample t-test[38] for

[38] One sample t-test is used when measuring if means is greater than zero. One sample t-test allows for comparison with baseline model when there are no group comparison is essential. One sample t-test compares the mean value with a t-test that provides a level of significance.

English only is N= 3091. The magnitude of the average found is significant $t(5,158) = 44.184$. The mean is .1248 and significantly different from 0, meaning each respondent experienced discrimination in at least one of the five cases.

As health paradox claims that regardless of discrimination individuals of Asian origin have better to good health outcomes. If this proposition holds, then there will be no relationship between discrimination and self assessed health outcomes. To test this hypothesis, a regression analysis is carried out. In the T-test model self-reported health is the outcome variable and discrimination is the independent variable. Other variables included in the overall model are controlled. The findings show that the effect of discrimination is low (β=0.001, p=0.150) and non-significant. To provide support to good outcomes of health, I use the findings from qualitative interviews that are illustrated more in-depth in the next chapter. In a brief summary, the qualitative findings from the next chapter on the outcomes of health show that almost all interviewees expressed that they have good health other than weight-gain. While the qualitative findings are not generalizable to the broader Asian population in this study, this is however an indication of potential existence of paradox among Asians controlling for financial status.

TABLE 8: Moderation effect of assimilation and discrimination on self-assessed health outcomes

Latent/Explanatory Variables	Estimates	Est/S.E. Z-value	Standardized Estimates	Standard Est/S.E.
Assimilation	3.437 (6.091)	0.564	0.146 (0.258)	0.564
Discrimination	0.830 (1.576)	0.527	0.105 (0.198)	0.527
QC14_D1: family Socialization	0.173*** (0.038)	4.503	0.076 (0.017)	4.503
QH2 : Religious Attendance	0.036*** (0.012)	3.107	0.052 (0.017)	3.107
QG_1: Financial Status	0.179*** (0.019)	9.377	0.157 (0.019)	9.377
QC18 : Civic Engagement in migration march	-0.399 * (0.181)	-2.206	-0.399 (0.181)	-2.206
QC19_2: Civic engagement country politics	-0.233** (0.097)	-2.394	-0.233 (0.097)	-2.394
QC14ASS2: Family socialization* assimilation	8.521 (6.761)	1.260	8.521 (6.761)	1.260

TABLE 8 (Cont'd)

QC14DIS : family socialization*discrimination	-0.376 (0.296)	-1.271	-0.376 (0.296)	-1.271
QC14DIS2: Work socialization*discrimination	-2.535 (2.321)	-1.092	-2.535 (2.321)	-1.092
QH2REL: religious attendance * assimilation	0.327 (0.961)	0.340	0.327 (0.961)	0.340
QH2RELD : religious attendance* discrimination	0.098 (0.325)	0.303	0.098 (0.325)	0.303
QG_1F : Financial status *assimilation	0.112 (0.389)	0.287	0.112 (0.389)	0.287
QC18SOC: Civic Engagement migration march*assimilation	-4.985 (2.627)	-1.898	-4.985 (2.627)	-1.898
QC19_2CD: Civic engagement country politics* discrimination	0.404 (0.591)	0.683	0.404 (0.591)	0.683
Intercepts Self-assessed physical health	3.537*** (0.364)	9.723	3.892*** (0.399)	9.752
Residual Variances Self-reported Physical health	0.959*** (0.007)	144.575	1.161 (0.028)	41.583
R^2 Self-assessed physical health			0.041 (0.007)	6.238

Note: N= 3458; ***p <.001; **p<0.01; *p<0.05; Dependent variable: Self-assessed physical health outcomes;

FIGURE 12: Mplus generated structural/moderation model of the study

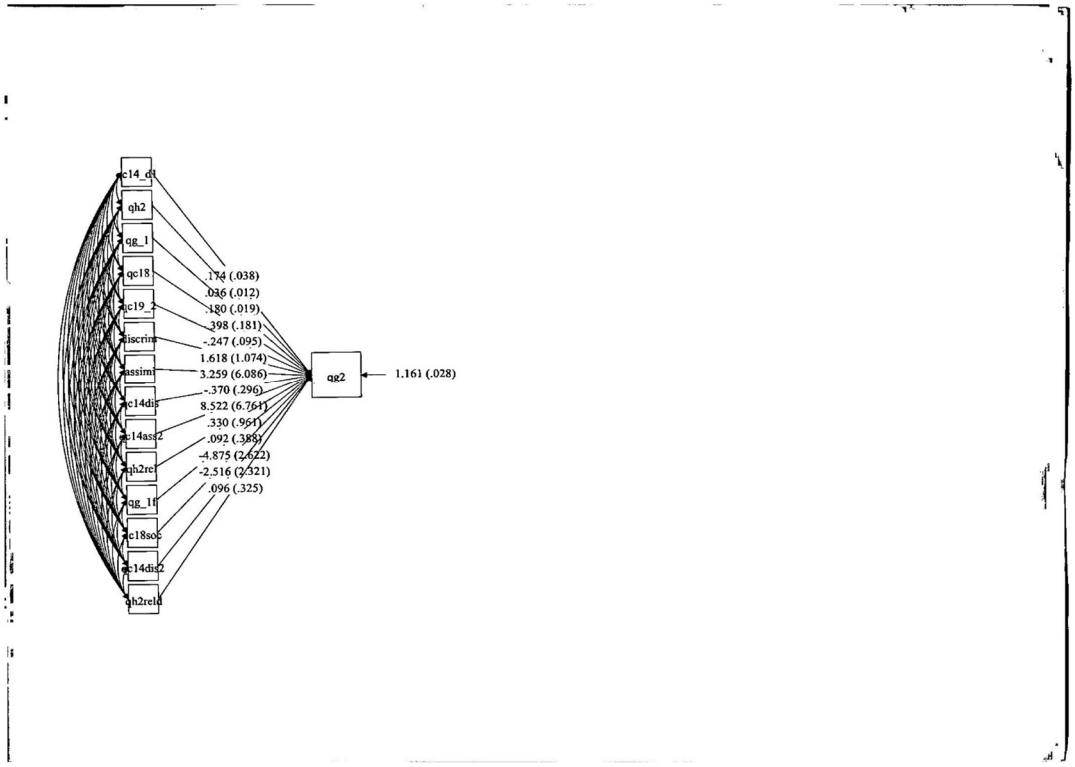


FIGURE 13: Measurement, full, and moderation effects combined model

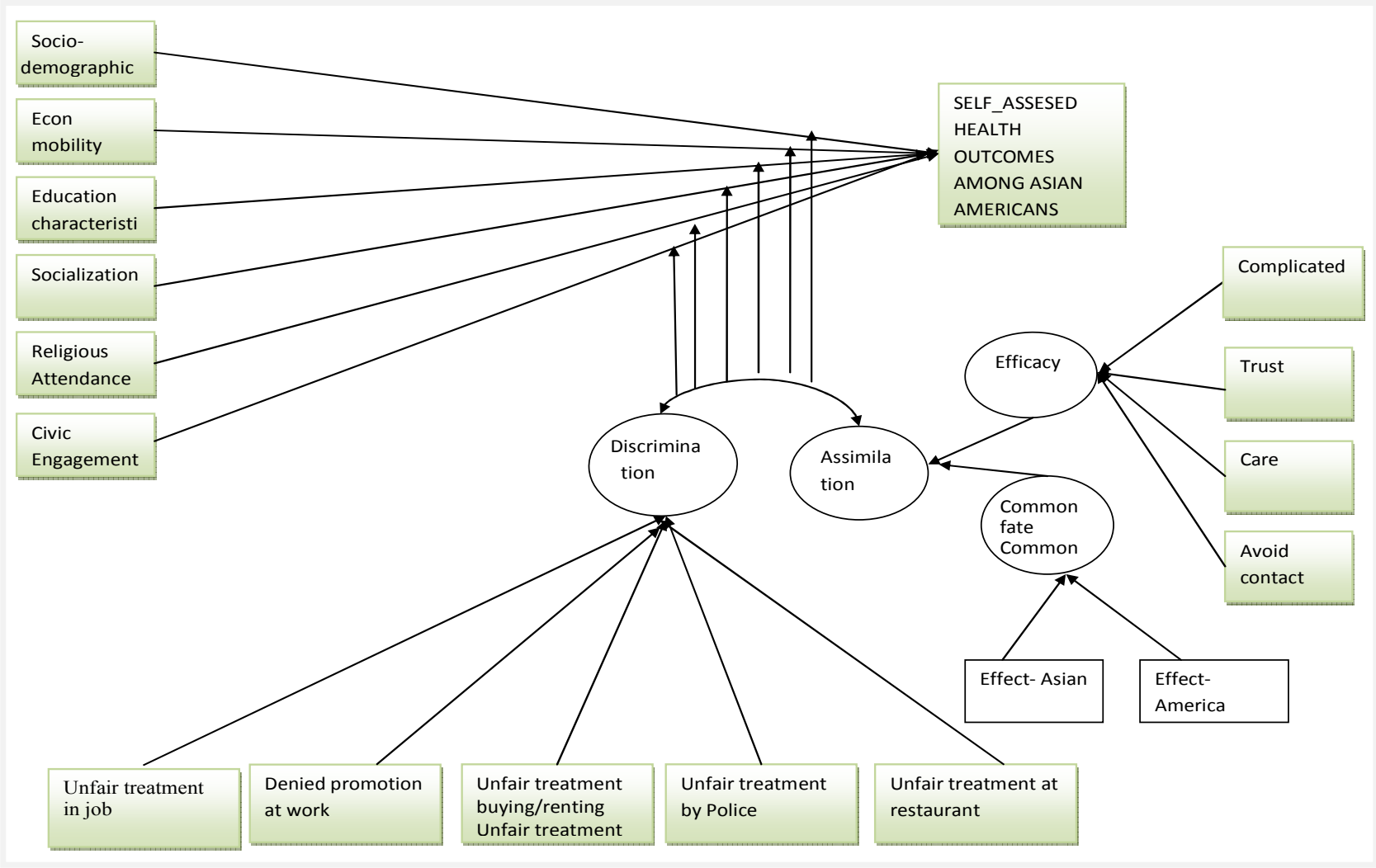


TABLE 9: Zero order correlations of the items of latent variables

	Politics complicated	We can trust government	Politicians care	Avoid contact	Unfair promotion	Unfair police	Unfair in renting buying house	Unfair at restaurants	In-group common fate	Out-group common fate	Self-assessed health	Gender
Politics complicated												
We can trust government	0.105											
Politicians care	0.047	0.304										
Avoid contact	0.153	0.082	0.052									
Unfair in job	0.045	0.049	0.045	0								
Unfair promotion	-0.019	0.067	0.092	-0.02	0.719							
Unfair police	-0.049	0.098	0.137	0.01	0.394	0.408						
Unfair in rent buy house	-0.012	-0.023	0.02	0.04	0.423	0.406	0.449					
Unfair at restaurants	-0.036	0.148	0.124	0.44	0.342	0.433	0.44	0.342				
In-group common fate	0.017	0.072	0.018	0.12	0.119	0.083	0.122	0.199	0.083			
What happens to	0.021	0.041	0.025	0.13	0.066	0.065	0.79	0.066	0.065	0.75		
Self-reported health	-0.048	-0.033	-0.022	0.08	0.03	0.025	0.139	0.068	0.025	0.039	0.068	
Gender	0.108	-0.03	0.037	0.17	-0.022	-0.01	0.01	-0.003	-0.009	0.01	-0.003	0.998

TABLE 10: Significance level of the zero-order correlations of the items of latent variables

Variable	Zero-Order Correlation
EFFICACY BY	
QG5_A politics complicated	-.475**
QG5_B we can trust our government	.543**
QG5_C public officials cares what we think	.553**
QG5_D better off avoiding govt.	-.478**
QF5_A Unfair treatment at job	.104*
QF5_B Unfair with promotion	.147**
QF5_C unfairly treated by police	.053
QF5_D unfairly treated in buying/renting house	.034
QF5_E unfairly treated at restaurants and stores	.103*
QF2A_1 What happens to other Asians effects	-.015
QF3A_1 What happens to other Americans affects	-.012
Efficacy	1.000**
Common Fate	-.005
QG2 Self-assessed health outcome ON	
Assimilation	.049**
Discrimination	.015
QC14_D1: Family Socialization	.053**
QH2 Religious Attendance	.002
QG_1 Financial Status	.117**
QC18 Civic Engagement in migration march	.020
QC19_2 Civic engagement country politics	.044**
DISCRIM WITH ASSIMI	-.170**

Note. N= 3216; ***p <.001; **p<0.01; *p<0.05

TABLE 11: Zero-order correlations of the full model variables

QG2 (How would you rate Self-assessed health?) (Dependent Variable)	
Latent/Explanatory Variables	Estimates
Assimilation	.049**
Discrimination	.015
QC14_D1: family Socialization	.053**
QH2 : Religious Attendance	.002
QG_1: Financial Status	.117**
QC18 : Civic Engagement in migration march	.020
QC19_2: Civic engagement country politics	.044**
QJ2: U.S. Specific Education	.340**
QS2_D7: Asian American vs. Others	.083**
QA1_D1: Chinese Ancestry vs. Others	-.091**
QA1_D2: Indian Ancestry vs. Others	.253**
QA1_D3: Filipino Ancestry vs. Others	.028*
QA1_D4: Vietnamese Ancestry Vs. Others	-.161**
QA1_D5: Korean Ancestry vs. Others	-.136**
QG5_A Politics so complicated	-.026
QG5_B Can trust our government	-.022
QG5_CPublic official care	.014
QG5_D better to avoid contact with govt.	-.001
QF5_A discrim at job	.023
QF5_B discrimination at work	.073**
QF5_C discrimination in buying house	.049**
QF5_D discrimination in	.015
QF5_E unfair treatment at restaurant	.053**
QF2A_1in-group fate	.002
QF3A_1out-group fate	.117**

TABLE 12: Zero-order correlations of the moderation model variables

Latent/Explanatory Variables	Zero-Order Correlation
Assimilation	.049**
Discrimination	.015
QC14_D1: family Socialization	.053**
QH2 : Religious Attendance	.002
QG_1: Financial Status	.117**
QC18 : Civic Engagement in migration march	.020
QC19_2: Civic engagement country politics	.044**
QC14ASS2: Family socialization* assimilation	-.007
QC14DIS : family socialization*discrimination	.022
QC14DIS2: Work socialization*discrimination	-.013
QH2REL: religious attendance * assimilation	-.028*
QH2RELD : religious attendance* discrimination	.012
QG_1F : Financial status *assimilation	-.010
QC18SOC: Civic Engagement migration march*assimilation	.006
QC19_2CD: Civic engagement country politics* discrimination	.057**

N= 3216; ***p <.001; **p<0.01; *p<0.05; Dependent variable: Self-assessed health outcomes

CHAPTER 5

QUALITATIVE FINDINGS

Introduction

In this study, using qualitative methods, I investigated whether and how social determinants affect health outcomes of immigrant and resident paramedics of Asian Indian origin in the U.S. Specifically, the qualitative method for this research includes oral history narratives borrowed from phenomenology tradition. The oral history narratives integrate memory driven data and the phenomenological tradition highlights experiences of emigration and living in the U.S. The research questions that I have posed along with the overarching social determinants discussed in the previous chapter were examined to assess their influence on health outcomes among Asian Indian paramedics living in the U.S. First, I will discuss the findings that relate to health and later, I will move on to the findings that highlight the topics related to the independent variables used in this study. The discussion of the results related to health outcomes will address my first research question. The additional findings on the topics included and measured by the independent variables of this study will provide direction for the future research trajectories connected to the lives of immigrants, immigrant families, and immigrant workers. These topics were indicated as important subjects by many of the study participants. To protect the identities of my study participants, all names of persons and businesses are changed in this dissertation. Only the names of geographical locations – towns, cities, and states – are left unchanged.

Narratives on decision to immigrate, feelings of immigration, and influences on health outcomes

According to Jasso et al., (2004), skill and health are compliments; those factors that generate skilled immigrants to emigrate also include healthier immigrants. This statement, along with a large number of studies, suggest that immigration is selective. Moreover, provided international migration is easily accessed and achieved when migrants possess skills and good health, then skills and health compliment immigration. Consistent with this idea, my findings show that paramedics of Asian Indian origin migrate, in part, because they possess skills that are favored in the U.S. These skills are linked with their aspirations to seek opportunities for better health. A quote from Leffers & Plotnic's 2011 study on nurses indicates a dimension of decision-making to emigrate to the U.S. that is similar to the findings in my study:

> Some nurses who have given years of service to people in need in their own communities have a desire to venture further from home for new experiences. [Understanding] what motivates [them] a study abroad or language immersion experience is better fit for learning [….] new culture. They can instead seek an adventure travel option (2011: p. 24, 25, 27)

This example emphasizes Abraham Maslow's approach to health called "being psychology" (Maslow & Cox, 1987, p.xxxv). The central ideas in Maslow and Cox's study illustrate that human beings have an innate tendency to move towards better health, creativity, and self-fulfillment. Embarking on this innate tendency to seek better opportunity and socio-cultural advancement is clearly initiated by aspirations, and emphasizes exploration in order to transcend acquired skill boundaries. Un-bordering of bordered experiences is mobilized through invoked euphoria of taking adventurous journeys. The euphoric feelings maintain momentum among legal, skilled, and aspiring immigrants looking for better opportunities to set the initial stages of adaptation uninterrupted by the external social forces of destination.

The findings from my research illustrate aspirations and motivations of exploration, concurrent with the highlighted suggestions from Leffers and Plotnic's (2011) ideas in the above quote. My research findings exemplify transcendence of the psychological bordering of health leading to production and reproduction of an attitude to achieve and grow as an individual. One of my respondents, who migrated before her husband[39], said

> Since childhood [I] wanted to explore and travel. I [remembering] came through the ad company and they kind of, you know, helped everything. the company was here but they were hiring people from India. So I think they had some kind of connection. I came with H2b visa. The [representative] from the company picked me up from the airport. "It's myself," [who decided to migrate to the U.S.] I didn't have any friends, one of my husband's friends they went to college together, you know, they're best friends. He kind of helped me. We had been posted [placed] at the same place, so in the same setting, we used to work in the same clinic. So he helped me too.

This narrative came from a female physical therapist who entered into the U.S. in 2002. She describes her immigration decision driven by self-motivation rather than a family-based choice. This opportunity served dual purposes: first, an advancement of her career goal to find a lucrative position in the U.S.; secondly, she viewed migration as her long-time dream to travel far and wide. Although the decision to migrate was self-initiated, the process of the respondents' immigration into the U.S. health care industry involved active recruiters from the U.S. based companies who were desperately seeking to fulfill labor demands in the health care

[39] A remarkable study by Sheba George (2005) illustrates how race, class and gender intersect when nurses (women) immigrate first and men follow. George describes that while nurses in her study become victims of societal stigma as lower class, sexually loose and too much independence, men who had lost their "social status" following immigration as dependents of nurse wives, attempt to regain ascribed dominant gender status in the U.S. by being an active member in their church. Contrary to their expectation, these men of lost status from origin are stigmatized by the upper class men in their church. In my study, this respondent is a female physical therapist who immigrated before her physical therapist husband. While they both possessed similar class status, the husband showed less trust in the broader American society than her wife. As will be described later in this chapter, the trust for the broader society, implying continue to live in upscale non-Hispanic White neighborhood, in this female therapist was primarily an outcome of ability to send children to good school. While her migration status as an immigrant in the U.S. instills into her a sense of freedom, at the intersection of structure and gender, her euphoria transforms into negotiating the U.S. structure for family reasons.

industry. This is posited in Maslow's central thesis: "business efficiency and personal growth are not incompatible; in fact, process of self-actualization leads each individual to the highest levels of efficiency" and improved psychological health (Maslow & Cox, 1987, p.xxxv). Nevertheless, in the context of self-assessed health, the ability to follow life desires shows patterns of socio-biological constructs leading to fulfillment of life's chances to formulate a stress free physiological health (Brunner, 2000). Furthermore, as described in the allostatic load hypothesis, the strong linkage between stress-induced damage facilitated by consistent response to stressors can contribute to cardiovascular disease, cancer, infection, cognitive disease and accelerated ageing (Hsiao, & Schmidt, 2015; Taylor, Blacklock, Hayward, Bidwell, & Laxmikanth et al., 2015; *See* Barr, 2008; Brunner, 2000). Among immigrants, stressors can come in psychosocial forms both from external and internal environments (Kaestner, Pearson, Keene, & Geronimus, 2009; Pascoe & Smart, 2009; Finch, Frank, &Vega, 2004; Finch & Vega, 2003).

An individual's desire to attain opportunity to advance is not the only reason to immigrate when socio-cultural patterns of a collective society, such as in India is concerned. Decisions of family members are interlinked with an individual's fate. Family ties play an important role in the decision to immigrate for individuals (Boyd, 1989; *See* Massey, Arango, Hugo, Kouaouci, & Pellegrino et al., 1993; Stark & Bloom 1985; Winters, De Janvry, & Sadoulet, 2001). While family connections ease the process of immigration (Massey & Durand 2002; Massey et al., 1993), immigrants' embeddedness in family structures consequently decreases the amount of stress associated with the process of immigration, entry, and adaptation into host nations. As such, a nurse living with her husband in the suburbs of greater Detroit area states that:

> It wasn't hard [with] my parents. It wasn't too hard because my parents came with us. So we just moved as a family. It wasn't hard.

Another nurse currently living in greater Lansing area also indicated migration was a family decision. Although in this case the immigration was led by family connection, the process of adjustment in maintaining a balanced life was difficult and echoes stress.

> Initially it was hard!
> The decision to migrate was following my husband, [after he earned his graduate degree from the U.S.,] we got married. So I migrated here. The plan was not to stay here but here we are. [I came to Michigan, but commuted back and forth from another neighboring state because we had our house at two different place.]. [For] 2 years, we did that up [and] down for a couple [of] years. It was hard as I got pregnant.

As this story posits, this nurse lived for some time under uncertain social conditions in terms of uniting with her family member which was the primary source of her coming to the U.S.

According to another respondent who is currently a resident of Greater Detroit area and works as an audiologist:

> I think for me to come to the U.S. was for better quality of higher education. I wanted to come here for school. I think my undergraduate education was really very helpful for me to come to this country. [In answer to the question on "your feelings after immigrating into the U.S." she said] Initially it was very challenging there was a big culture shock and especially for me, I never lived away from home and never lived anywhere else. But now I think I have adapted to the change. There is difference from my first semester when I came here and now that I am working. But, yes, I think I have adapted.

More evidence show feelings of culture shock, as depicted in the quote below,

> Yes, it does. In the beginning it was totally a cultural shock. It was a lot of anxiety, lot of new things to deal with. But the things are not the same now at this time after 34 plus years. Now we have spent so much lifetime here, learned lots of things, had children. It's just my whole life kind of went by here. So this experience is much, much, much different because we now know where we are, what we are, what we are expected.

While better opportunity, higher education, family connection and influence, and marriage are among the various reasons for deciding to immigrate into the U.S., the emotions associated with migration have an immense effect on health. Upon entry into the U.S., immigrants experienced challenges, culture-shock, hardships, and stress. At the same time, the other side of health spectrum is also visible in health outcomes following entry into the U.S. among paramedics of Asian Indian origin. For example, patterns from another nurse's story reveal euphoric experiences of migrating to the U.S. – although the decision was primarily made by her husband and she later followed. The initial idea of emigrating into the U.S. gave her immense mental pleasure, revealing positive socio-psychological health:

> Well when I came the first time we were very excited! Like we just were like praying that everything goes well in immigration and we get the visa and everything just falls through. And we prayed about it as if like oh what a big deal! Of course at the time when we decided to come to the U.S., I was married so it was majorly decided as together but of course the husband's decision was primary. When I got married my husband was in the Middle East and I was in the Middle East for a while and then we decided that we want to move on from the Middle East because once we have children we want to give them a better future. So America was, at that time, in physical therap[y], very prosperous, with the family [therapy]. So we thought with the family, let's explore this! So, before we had children we can migrate to there so our children can have a better education. At the time we had the impression that America is the best country so we thought that oh! let's just go explore when we are young, rather than send the children later for the higher studies and difficult to settle at the later age. So we decided as a family as a husband and wife to come here.

For a male physical therapist, the good health outcomes as an immigrant making adjustment in the U.S. after initial entry is expressed in relation to space. In his following words:

> Myself and my wife [made the decision to immigrate]. My wife was my girl friend at that time so … I came to MI and I came from New Delhi where currently, well at that time, there was about 12million now -13 million people in one city. Now it's about 20 million. I came to a small town in MI which is probably 100000 people altogether and so it was a very small place for me and somehow I didn't like small towns. So I kind of moved, within 10 months I quit my job, got another job in another place which was closer to Detroit area and I worked at that place. Somehow I found it was even … about same: Very small

> place to work, but where I lived was in [suburbs as well], which is much closer to Detroit. So I could go to Detroit area, suburbs, and have a feeling of … like a big city feeling. I worked there for about one and a half years, then I got an opportunity to come to Greater Lansing. When I came on a weekend to help out, like as a filler. So, I liked this, it was perfect sized and it was not very big, or very small. The traffic was not a problem. But at the same time there were like 2-3 malls, so it was a right size of a city. So I decided to come here and since then I moved here, I think, in 95. So I've been here since then. (Since 95? Because of the town you moved here?) Yes!

Based on this narration, the decision to migrate is not a simple act of moving from one place to another (Massey, Durand, & Malone, 2002), neither it is only a response to labor demand in developed countries; it is a process that encompasses consideration of multiple trajectories. Clearly, as one male physical therapist in his mid-30s and another nurse in her mid-40s describe the experiences of their migration reflects the embodiment of complexity in this decision making. Increasing complexity, uncertainty, and greater imbalance in immigration process are precursors of higher levels of distress and vulnerability in immigrants' adjustment. In complex situations like this where probabilities of stressful experiences are high, research has shown that role of family plays an important role in mitigating the stress (Landale et al.,1999). Complexity of immigration experiences can minimize euphoric feelings while simultaneously increasing feelings of despair, which is as reflected in the following quote.

> … my current position is since 2006 since I moved to [Greater]Lansing I have been working here. I am a physical therapist. When I finished my PT studies..ah! ... when I finished my PT studies in 2001 … ahh … I was not really keen on which direction I wanted to go; whether I wanted to go to U.S. or U.K., or continue working in India … after finishing my studies, for a year and a half I worked in a non-profit organization in India. So I worked over there for about a year and a half. Meanwhile, the owner of that practice; he has a clinic in Michigan. So he offered me a position as a PT and so he was working on my work permit and we were not sure how it would work out. Meanwhile, I got admission in a post-graduate study in U.K. So I went over there for my post graduate studies and that's when I got a call from the owner in Michigan. So they basically told me that my work permit got approved. And that's when I came over to U.S. Ahh … I have been here for closer to 10 or 12 years now. So looking at it, my lifestyle over here and what it would have been in India, I see

> some of the things being different … like not staying around a joint-family system is a main difference I can see. But other than that, my working style… has been nearly the same over here and over in India. (Q.Were you living in joint family in India?) Yes!

Similarly, another therapist's story reveals gradual acceptance to initial shock of low levels of interaction among people.

> Well I'm more accepting of the culture now as compared to what it was before. I did get a [culture] shock once I got here. First of all it was not the America of my dreams it was a very laid back town that I came to. This is I guess ten times better than it used to be when I came here 13 years ago. Lived in [Greater] Lansing and I was just surprised to see only cars everywhere around. I could not see any people and that kind of freaked me out where you're used to when you go in the evening it's like people [socializing], [buying] potatoes and bananas and onions for this much and that much. And there are people around you everywhere and all you see here is cars. So that was something different but it doesn't bother me anymore. I'm more acceptant of the culture and I like it here.

From these narratives, it is clear that whether it is decision to migrate or phases of initial adjustments, both the robust euphoric U-curve of immigrants' adjustment and Young Yun Kim's cyclical stress-adaptation model are moderately satisfied. The U-curve states that immigrants experience honeymoon phase just after their entry into the host society, while longer stay and gradual exposure and adjustment to structural and social experiences in the host society leads to anxiety. Anxiety and negative emotions consequently lead to a rejection of the host society, forming the third stage in immigrants' adaptation. However, further stay stabilizes immigrants' adjustment process. In the third stage, immigrants reject the norms and values of the host country which results in continuous experiences of stress. Similarly, in classical sociology, following Social Darwinism, Robert E. Park (1950) have indicated that social interaction flows through stages of contact, conflict, competition, assimilation, and accommodation. An emphasis on contact hypothesis posits that after being "othered" in the host society, immigrants experience differences that could lead to conflicts.

The histories reflected in this dissertation on decisions to and feelings about migration and their influences on health clearly speaks similar stories of stress and distress in the initial and middle phases of adjustment among paramedics of Asian Indian origin. In relation to euphoric experiences, during first the year of immigration, my findings show mixed results. While those who migrated as skilled-immigrants indicate contact with the host and transitions thereafter as more challenging as compared to ones who migrated with family members or through networks and connections. These migration patterns have significant implications for health outcomes. Disruption effect, allostatic load, euphoria, self-actualization and mental health are some of the dimensions of health outcomes influenced by social process of immigration. In relation to physical health outcomes, research finds that stress and more specifically chronic stress has negative influence on physical health within cause and cause-specific outcomes (Barr, 2008).

Narratives on sense of belonging and health outcomes

Hagerty and colleagues (1996) have found that sense of belonging is a potentially meaningful measure of social and psychological functioning (Hagerty et al. 1996). They define sense of belonging as the "experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment" (p. 173). According to Hagerty and colleagues (1996, 1992 original emphasis) the proposed "consequences of belonging are (1) psychological, social, spiritual, or physical involvement; (2) attribution of meaningfulness to that involvement; and (3) establishment or fortification of a fundamental foundation for emotional, cognitive, and behavioral responses" (p. 236). In their proposed model of sense of belonging (Hagerty et al., 1996), they emphasize that sense of

belonging is a "psychological experience with both cognitive and affective components that is associated with affiliative behavior and psychological and social functioning" (p.236). Additionally, a wide range of studies have found association of sense of belonging with positive health outcomes. The assimilation behavior among paramedics of Asian Indian origin is primarily analyzed through their narratives on a sense of belonging in the U.S. When asked if during the duration of their stay they feel that they belong in the U.S., a significant number of paramedics described their a moderate sense of belonging in the host nation with longer durations of stay. The emphasis on moderate outcomes of sense of belonging pertains to living both in the U.S. and India simultaneously because of immediate and extended family connections.

Additionally, for some respondents the quality of overall health care in India including low cost health care services, providers, facilities and social relations and connections determined positive connections between belonging and health in India rather than the U.S. Others expressed their sense of belonging in terms of "feeling of home because of living day-to-day life in the U.S.," or "feeling of home because of living in a "user-friendly" system," or "feeling of home because "we have build our house in the U.S." In a true sense, feelings of belonging in association with objectivity produce positive health outcomes among paramedics. Although, in some cases feelings of belonging resonated with the sense of stability, security and settlement in relation to socioeconomic standing, this implies living the "American dream. " Apparently, respondents were somewhat hesitant to express belonging in the U.S. This implies sense of belonging is associated with mixed health outcomes among paramedics of Asian Indian origin. More specifically, sense of belonging is associated with conditional health outcomes among Asian Indian paramedics.

An important and repeated observation in regards to sense of belonging included the ability to live closer to their children who were mostly adults, attending college or working in the U.S. On the other hand, the influence of feelings of belonging on health provided mixed outcomes when respondents felt that they have existing family connections in India. An evidence of feelings of belonging as a consequence of self-assessed health outcomes is reflected in these words of a speech therapist:

> That's a hard question. I think I belong here, yes. But in the beginning I always missed my parents and my home but I think I belong here. Because I've been here so many years, I'm comfortable, my kids are here. I'm just going with the flow. But at times I miss my home too because part of my family is living there. I always remember about them. But now when I go back there I don't feel I belong there because it's so different. My friends are different, it's so different. But if I'm home with my family, yes! I belong there.

The holistic nature of the "sense of belonging" question motivated me to integrate memory-driven oral history interviews into the phenomenological tradition of data collection. A crucial understanding in phenomenological research states that the essential description of lived human experience is obtained through developing in-depth relationship that occur in in-depth interviewing processes between the researcher and subjects (Beck, 1994). Therefore, to obtain clarity on more lived experiences, I asked if spending after a few days back in India do respondents feel restless upon returning to the U.S.? The same respondent said,

> No it's not that kind of feeling. Because I have my home and this is my place. So I go there and then I think I have to go back home. Because that's my home, I have to take care of on that. I have my family my kids have to go to school. I have to teach them, they are growing. It's your responsibility, so you have to go back [to the U.S]!

As another nurse who lives in Greater Detroit area and is also currently attending school pointed out,

> up [now] ... Now I think I belong here, but I still consider myself Indian. But now, we have our house and our friends, all our family is here. So, I kind of feel

> like I'm here for good. It took me a long time to think that I belong here. Since my kids were both born here….so [I can say that I belong here] They are grown-up now..

Similarly, another respondent indicates

> I will give you a serious answer because I have seriously thought about it. I have lived here long enough to call it home because all my friends are here, all the relationships I have made after getting married are over here. At the same time, it's whenever I visit back and see my parents that I always want to go back there. But I am afraid to be old in the U.S. because of the amount of ... well compared to the amount of health you get in India. But after giving it even further thought that my kids don't want to go back and don't want to settle in India, they want to settle in the U.S., I strongly feel I want to settle here too because I want to be closer to my children. And my parents visited me because I had a baby, because I built a new house so such important occasions. And I don't want to do that to my kids, I wanted to be involved in kind of their daily lives. Maybe not every day but I want to see them at least ten times in a year and not just once every two years like my parents did. So that's what makes me feel here. Maybe socially if you are well off you have all kinds of things over there, like we have a house there right now. Maybe we can go back there and live for some years if the kids don't do it, they can come there. And my kids are ok with coming to India, they visit every year or alternate year, so they know how India is. They love it there. And they love it here. But if you ask them where they'd like to settle they say in the U.S. And a lot is where your friends are, you want to be where your friends are. You want to be where people know you and the structure, day to day life is easier here.

In classical and grand theories, the depiction of health varies across different theoretical avenues, particularly functionalism, conflict, and symbolic interactionism. For example, functionalists would argue that proper functioning of society demands good health; conflict theorist state that disadvantaged experience poor health outcomes compared to people with better socioeconomic standing; while interactionists would say that health is assumed as ill only when society describes it as malfunctioning. Borrowing from social-psychological perspectives, attitude and emotional constructs have gained importance in assigning meaning to sociological constructs. In the context of belonging, Yuval-Davis (2011) notes, feelings/sense of belonging is expressed through emotional

attachment such as, feeling "at home" (Yuval-Davis, 2006, p.197). This idea inherently embodies a sense of healthy living. Although sense of belong among paramedics in the U.S. has mixed outcomes that is reflected through mixed emotions and attachments to the context of destination overall, health narratives reflect a positive attitude towards living. In spite of their stressful and intense work expectations, paramedics produce and reproduce health through each and every living experience and situation. In most cases, their health is ethnically driven rather than bestowed upon them through broader structure as some of the narratives in the next section will reflect.

Experiences of discrimination and health outcomes

Research on the effect of discrimination on outcomes of health reveal mixed findings (Williams, Neighbor, & Jackson, 2003; Krieger, 2000; Broman, 1995). While some studies find a negative relationship between racial discrimination and health, others have found no relationship between cardiovascular disease and hypertension with racial discrimination among African Americans (Broman, 1995), who are perceived as situated in the lowest strata of racial and ethnic hierarchy in a race conscious society (Bonilla-Silva, 2006) such as the U.S. Important findings on how the experiences of discrimination might affect health among Asian Indian paramedics in the U.S. are illustrated below: close to two-thirds of my respondents expressed experiencing some form of racial and ethnic discrimination. A nurse in her mid 50s, living in greater Lansing area sums her thoughtful story of discrimination in the following words:

> Regarding accent, it depends on [the] patients. Some patients will have that, they are biased, or sometimes it's not personal or you should take it, it's not personal, but there are a few people who feel you don't belong here or you shouldn't be. Or do not attempt to understand you just because they look at you

> and feel you have an accent, which I acknowledge I do have an accent, but who will not attempt to understand or… and the way my work is it's more of a service industry. I am here to make them better or see what their needs are so I am trying my hardest to help them. But sometimes they will feel they don't want help from you just because they think you are not, because you are different. Because you're different! Or sometimes somebody will start talking to you in Mexican thinking you're Mexican and then, which you aren't, [or] they feel "ok then it's something worse or somebody different." But on average most of the times… no, I haven't felt like that. Occasionally there are going to be, in 25 years of your life there is going to somebody who just looks at you and think[s] "I don't like this person." Honestly on average never felt the treatment was unfair. Always felt I was respected. At work, have always felt like I was respected for my knowledge and respected for my conduct.

Similarly, another nurse who is retired now and is in her mid 60s expresses her experiences with discrimination that concurs with the previous finding. In her experience, discrimination is associated with her shift work.

> It burns them out! [I was] a shift worker. Yeah I have felt, in my work time I have felt… because of my race and all that certain things that I was not given. But otherwise in general like in restaurants and buying property I don't feel anything like that. Well you know there are certain physicians I believe they would prefer to give to Americans not Asians because of the cultural difference or accent or whatever they may think. Like manager positions. Yes! Especially in my workplace. This is patient care and it's very tense and the crisis sometime happen when there is short staff, that's the biggest problem. When the workload is more, then the staff can't handle it. It is impossible to handle the workload when there is short of staff in relation to patient demand. And the care gets very much regulated. It's a big crisis! People can't handle it! Some people quit jobs because of it, it burns them out!

A physical therapist in her mid-30s expresses her discrimination as follows:

> That was not a thrilling experience! Well I didn't face any problem as far as English is concerned but faced problems with the accent and didn't know the slangs. There are certain ways things are spoken, didn't know that. I was in the market to look for jobs right at the beginning and was extremely shy, very nervous, very inwardly drawn about how I speak and how I talk is how I'll be perceived. I always kind of thought that people wouldn't be very accepting, and it was that way for a couple of the job interviews that I did. There were some people that laughed at what I said and how I said it, that it didn't make any sense or they made a joke out of it. That was not a thrilling experience. I'm not a quitter, so I wanted to learn what they knew, so I could be better at it. Actually the first few years of going to school helped a lot. Those first few years helped

> shape a lot of the accent, shaped a lot of the culture of the place, and I had very good friends that helped me early on saying this is what that person was meaning or this is what it means when they say this!

Similarly, although another physical therapist repeats the same experience in her story, she is, however, resilient against the experiences of discrimination and maintains a neutral attitude.

> Never. I've never had racial discrimination, just once in a while, again very seldom, but I've had patients that wouldn't want to work with a colored person. But other than that I haven't faced anything of the sort in the United States. They mentioned. They mentioned to my supervisor that they did not want to work with a colored person. They were very old patients. And I do not hold anything against them. Just because they did not want to work with a colored person. Simple.

Another respondent, a speech therapist, indicates her experience with discrimination that directly contradicts opinions of the previous respondents':

> No I've been treated very good, I haven't had any problems. So far I don't have any bad information or bad memory about, overall I've been treated good, treated well. [unfair denial of promotion?] No! I never had those problems. No. [buying a house?] It was good, we had to look for some. We had to like the house otherwise we didn't have any problem.

Almost all of my respondents experienced discrimination in some form, at levels ranging from low, moderate, to high. Respondents express negative feelings to experiences of discrimination. Although studies have observed that post-discrimination stages can lead to thwarted aspirations, coping strategies among Asian Indian paramedics to these experience include adapting to positive multifaceted strategies in overcoming the unhealthy consequences of discrimination. As emphasized in prior narratives, for many family reliance buffers the negative outcomes of health. Maintaining a positive attitude to life motivates them to stay engaged in leading an active work and family life. It is likely that this attitude helps

them maintain a positive balance of healthy outcomes in living a stressful life contextual to discrimination. For example, as stated by another physical therapist,

> I'm not a quitter so I wanted to learn what they knew so I could be better at it. So I'm at a point where they ask me if I was born and brought up here. So I kind of, knowing their slangs and culture, I'm able to challenge them if they challenge me. Not anymore, [thinks] but in the beginning yes for the first couple years.

Another therapist reflects on experiences of job promotion:

> I don't know. Initially when you come, you probably don't know a lot of stuff, so it's just that you have to learn. But if you have your own grounds, you stand on your own grounds and explain to them, probably you can do that. I think it's probably culture and racism, I don't understand. I don't know about that much about coming up in life or a promotion or stuff like that. I think it's just a personality conflict, everywhere you go. And of course, your personality goes into this racism.

According to this therapist, the negative experiences in her workplace were due to personality conflict rather than coloration, individual or institutional discrimination, or marginalization. Although the relationship between discrimination and health outcomes seems to be simple, yet there is a data dearth regarding the effects of discrimination on population health (Krieger, 2000). Based on my findings, I argue that the effects of discrimination is "bad" not only because a negative behavior such as this is likely to harm health, but any unjust behaviors targeted at a fellow human being and eradicating their basic rights to live a decent, dignified and happy life is negative and stressful in itself (Krieger, 2000). The treatment of discrimination expresses to its victims a sense of unworthiness, hence experiencing it means significant chances of poor health outcomes.

Narratives of self-assessed health outcomes

Similar to the experiences of discrimination that has mixed outcomes, self-assessed health reports contain positive attitudes towards health outcomes. Concurrent with the

literature (see Barr, 2008 for multiple dimensions of health), understanding of health among paramedics is multifold and situated in biological/physical, behavioral, cultural, and social characteristics. The findings on health are described as:

> Health-wise I think my health is good. And I think, you know, I eat more healthy and I'm more active than when I was younger. And I have my kids so I'm always running after them! Health is subjective.

Another respondent, a physical therapist stresses following narratives on health:

> I've always been a healthy individual. I've never been on the skinniest side which sometimes when you're growing as a teen or as an older adult would affect you because it's all about looking pretty, getting into smaller sizes. And besides weight, which of course I'm not obese or overweight, but never been on the skinnier side. That's the only potential health challenge I have, other than that nothing has changed.

Living in an unhealthy relationship was described as a responsible agent of poor health outcomes.

> My relationship is the big part of it. I don't know. I kind of sometimes think about it but [I feel] controlled in my relationship. He's a different individual, I raised my kids like a single mom. He wasn't there anyways. And he openly admits that he doesn't want to keep the kids, he doesn't want it documented. Other than that I've been fortunate not to have any major health issues. Mentally I feel a lot healthier than before. I feel liberated. Physically I feel I was much better when I came here and I've gained lots of pounds now and I want to work out. Sometimes it becomes hard to tell [patients] to strengthen their core when your core is so flabby. So yeah, I'm not on the healthy side physically. Emotionally, mentally I'm on the healthier side compared to what I was before. I was very excited when I came here and life kind of took its turn and lost all its luster.

According to the following narrative from a nurse, health embodies the attitude :

> My past health status was good, very good, always very active. Been very athletic even married with children. Played badminton, table tennis, walked, jogged. And joined gym. But now, I still walk, cannot do very strenuous things, but still I am ok, I have minor arthritis but not as 100% percent on the scale as I was but not bad

Another nurse reflecting on health outcomes indicates,

> Yes, my food habit changed with the thing that was there when I was not here. We have totally Indian food, totally according to family and background status, religious status. Like my grandmother didn't believe in onions and garlic. But the new generation did believe and ate. And of course we are vegetarian. Arriving in the joint family we always had to cook. So then it was always ready. But after coming here it was all by myself so it became a matter of convenience. Though I did cook most of the time, I did cook as we cook in India. But sometimes it changes like every time we have 3 meals, we can't keep up with 3 meals so we have left overs. You know, eat rice, dal, something. So things change according to life, [referring to eating left overs than fresh as did earlier].

The above quotes show that self-assessed health outcomes differ for paramedics. Overall, paramedics stay hopeful about their health and hold positive views. Most of them express positive health outcomes.

Civic engagement narratives and health outcomes

When asked about civic and community participation, several respondents integrated their community engagement with religiosity or religious attendance and volunteering, combining both as mutually exhaustive categories. As narrated from memory by one of the nurse practitioners, 60 and above years of age,

> But, I always like to help, whenever I came to know someone into crisis, any friend, whether it's American or Indian, which I have. In my life, people have called me in the middle of the night any time of day. I have slept in the hospital for my friend who was sick after working for 12 hours. I have rushed, one time somebody called me some lady is down on the floor and can you reach, I reach. And a friend was very sick, couldn't get up, so I went and cooked dinner at her home. So if I have time and can do I would love to do it. It depends on the priority. If somebody is sick and needs somebody immediately and I am available, I'll go. No problem. Temple engagement is a priority as well!

Paramedics from this research are significantly active and regularly volunteer in their religious institutions. Some of them hold administrative positions and devote time for community work, such as cleaning the temple premises, cooking for religious events, or volunteering to offer *Gita* (Hindu religious text) classes for children. On a day-to-day basis,

they aspire to remain more involved in their respective temples and other forms of community engagement. In most cases, their deeper involvement shows a means to build social capital. For example, for my respondents absolute commitment to the temple work signified a major involvement in the community. After the initial appointment with the point person, recruitment for further interviews became easy to access as a large number are in-network paramedics involved in temple activities. . This allowed me to gain a list of paramedics, some of whom agreed to be part of my research. This finding connects with the concept of social capital, which is defined as the ways in which people connect with each acquaintances including friends and neighbors (Viswanath, Steele & Finnegan, 2006). In their study, Viswanath and colleagues (2006) have found that greater integration within a community network increases the likelihood of exposure to valuable health information. Active engagement with their religious organization and fellow paramedics (as in some cases they initiated emigration to the U.S.) could be a reason that my research participants assess their health positively.

Narratives of religious attendance, socialization and health

Religious attendance among paramedics overlaps with sub-ethnic socialization practices of India and sub-ethnic membership of Indian origin. However, the religious practices differ among attendees by regional Indian sub-ethnic groups, the major difference being attendees of South India and North India. This evidence is found from the fact that one of the main priests of the temple is from South and the other is from the North. The temple remains open for both weekly and weekend services every day, morning, and evening. The temple hosts major festivals from the Indian-subcontinent for the people living in Greater Detroit area. The temple administration is structured around a bureaucratic system, where the bylaws are constructed by the Board of Trustees. Primary consultations are made with one or more members of the Board

of Trustees for occasions that individuals and families show interest in renting the temple premises to observe any particular religious performance. The members of the Board usually assume the primary responsibilities to oversee the functioning of the temple in greater Lansing..

In the context of the U.S., the temples experience interesting and contrasting challenges that topples the characteristics of power inherent in caste system of the Indian society. Whereas in India, it is invariably the priestly caste who exercises maximum power within the premises of temple and in its maintenance; in the U.S., although the caste lines dissolve completely, they are often demarcated through religious practices prominently. It is always an emergent question for the continued practice and to remain a member of the temple, how the temple will be funded and who can invest large sums of money for the temple maintenance. In addition to class lines, ethnic demarcations strongly overlap with class for the maximum allowance of religious practices in this temple. For example, when respondents were asked if they have been able to maintain cultural values, beliefs, and traditions of the origin, the responses combined described an emergent assimilation pattern in associated with integration. The pattern that emerged from the narratives included celebration of Diwali and incorporation of non-Indian acquaintances and friends. A 32 years old female nurse who came into the U.S. at a very early age stated that

> "My religious background, I'm pretty much secular but mostly Hindu." I want to say about 80 to 90 percent. I and my husband take, we play a very active role in the international cultural association and the program that he's involved. When we just had Diwali, I want to say about 2 weeks ago, we did organize, I shouldn't say organize, we helped the international cultural association organize the whole festival and explained to our non-Indian friends what the background of the festival is, what we do, and even hosted a pot luck Diwali lunch for everybody. Trying … getting there."

These sentiments clearly show that although sub-ethnic Indian groups take pride in their religious practices, a grounded strength of this pride develops from viewing it as a part of the broader community and in some cases, as a global symbolization. These emotions

reflect a continuous struggle with assimilation; and for skilled immigrants of color, the nature of assimilation as defined by the U.S. scholars, is negotiated by the skilled immigrants maintaining a safe internalization of proactive assimilation. More specifically, Hindu paramedics confirm an understanding of assimilation, which they believe needs to be initiated by them in order to be considered as an integral part of the American society. Hence, assimilation is viewed as a proactive measure of the ethnic individuals and groups and the tendency to follow assimilation as an structurally induced mode of practice remains absent from their expectations. In essence, assimilation is pro-actively exercised by the paramedics by exposing mainstream culture to that of Indian origin. This social process simultaneously involves ethnic-welcoming to ensure their self-acceptance by the mainstream America. This ethnic-initiative characteristic of proactive assimilation is further enhanced by Asian Indian paramedics' class/skill sets.

Another female respondent, who took a voluntary retirement from her nursing job, and currently stays at home, resonates similar sentiments in the following narrative:

> Well, we were celebrating Diwali in the hospital. So every time at Diwali time I arranged a lunch. And we had little decorations, a little flyer to say what is Diwali, and just to expose people and let them know. Because there are lots of Indian people who work there It became a good program every year, very famous!

Although Diwali has religious implications and originates from Hindu philosophy, it is less likely that the core religious ideas behind Diwali are resonating in respondent's narratives when they discussed attempts to make religiously grounded celebrations into a more socio-ethnic festivities. The narratives reflect respondents' attitude towards mainstream assimilation in the U.S. society and resonates with the thought that they adopted a form of assimilation proactive in nature by allowing non-Hispanic Whites to integrate while ultimately clearing

their own path of integration rather than awaiting acceptance from structure, which is assumed by the traditional mode of assimilation into the U.S. society. The proactive assimilation and integration continuum served as a social construct model. According to this model, Asian paramedics momentarily blurred the lines of distinctions between patterns of cultural assimilation, while molding socio-religious and socio-ethnic characteristics into one. This promoted immigrants position as human-agencies who can change the shape of main stream organizations. Nonetheless, despite self-effort to assimilate, the experiences expressed through Asian Indian paramedics' narratives are not devoid of everyday and institutional experiences of discriminations.

Reflecting on socialization within the neighborhood, one male physical therapist living in an exclusively upscale neighborhood expressed the following:

> I don't know much because I [only] had couple of friends in my neighbor. But I said "hi" "hello" that's all. Only 2 other people I know [lives] behind me; John, I talk to him. And another neighbor: Dr. Pastor. We just became friend, that's all! Other neighbors: if I see them, only "hi" "hello" that's all! I don't know much anything about Tim. [Researcher: **Do you socialize with your neighbors**?] Only Dr. Pastor and John, that's all!

Upon asking this same respondent about his health outcomes, he replied that overall his health is fine except for recent weight gain. This example shows a sense of isolation and social distance associated with living in the U.S. non-Hispanic White dominated neighborhoods. Similarly, another piece of narrative evidence from a non-Hispanic, non-White/European descendant respondent who currently is a nurse, grew up in the U.S, and is married to a lawyer:

> Upon asking: [**Did you ever feel helpless, powerless, or socioeconomically insecure in U.S.? Describe those specific moments ... and your current health status]** Yes, I think particularly my teenage years, I felt very insecure about who I was; specifically related to not being American … or looking American. I also…In my adulthood I regained more confidence in myself, but I

> think there are … I mean every once in a while there are still times where...not so much anymore I guess. But…There are times…particularly when I was young that I reflected on … I think I was really depressed about who I was and, as related to my ethnicity, I was kind of … I just wanted to more than anything look like everybody else. I wanted to eat the same food as everybody else. I didn't want my mom to act so weird around my friends. I wanted for her to act more … my mom and dad to act more American.

Although this respondent is aware of her poor socialization prospects as an Asian Indian in the U.S., as a nurse practitioner, she views health as a biological determinant and carries an internalized blame perspective to her health.

> My current health status is largely healthy. So I do have some hormonal problems; Polycystic Ovary Syndrome which is highly linked with…I understand that Asian Indians actually have a higher incidence of this metabolic condition called Polycystic Ovary Syndrome. So it was difficult in me becoming pregnant; it took me many years to become pregnant and I still kind of struggle with the symptoms of it. But aside from maintaining a balance with that disease, I'm rather healthy. *Any reasons responsible for your current health status?* I think the only reason for that is only attributable to genetics. I am blaming genetics for that but also I certainly could be exercising more. I think I eat well, but I need to exercise. So that is certainly a contributor to my health … you know, not being optimal health.

Narratives of sociopolitical incorporation and health

Findings do not show significant interest and engagement among male and female Asian Indian paramedics. However, when political engagement was framed in terms of collective formation, respondents comprehended their political situation as a condition that is realistic and reachable. Furthermore, they viewed themselves as human agents, functioning as part of a socio- political construct and their engagement with politics as a reality through a community engagement perspective. This reflects in their initial hesitation to speak about their involvement with politics. However, when the term 'politics' was replaced with 'community engagement' in questioning, respondents showed more willingness to answer the question, which was primarily reflected through their experiences on community engagement. Hence, when asked: "How

often do you think you are able to participate in community activities within your locality that contributes to mainstream society? For example, food drives, immigration marches, or any other community activities?" a female physical therapist in her mid to late twenties of north Indian origin living in the greater Lansing area with her student husband said that

> I want to say about 5 percent of my time, not much or as much as I would want to.
> Normally I do a lot of volunteer work back in India as in reaching out for the underprivileged. I'm also signed up with the local pro-bono physical therapy services for any unfortunate people if they cannot afford it at this point. But nothing besides that!

Upon being asked if they ever thought of or worked as a community developer in their country of origin or in the global community, the respondent replied,

> In India I did not, when I was. I was a student, I was young and I was not married. Here I have been in Indian organizations, I have been involved. I have been in Indian cultural societies, part of it, [in] their board. And I have been a part of temple board, very much involved. Other than that, at my work I also participated in a diversity group to celebrate work festivities, I started that [as well].

Taking part in community organizations and community development initiatives is self-explanatory in relation to health enrichment. A lack of health would forbid any such participation, motivation or emotion.

Narratives of socioeconomic status and health

Socioeconomic narratives range across the board, from everyday discrimination to neighborhood isolation. Most of my respondents, however, state that they have been able to overcome their initial struggles to achieve socioeconomic advancement in the U.S. In addition, almost all of them indicated that the neighborhoods in which they currently live are upscale residential areas. The decision to reside in a neighborhood is primarily driven by their cultural trend to prioritize providing good schooling for their children.

> I own it [home]. The neighborhood I live now currently I would say is not very rich, it's right in between. Very, very economically good area! The people are very professional around my neighborhood. We are very friendly, nice, and very well off I would say. I am not employed, currently, I am retired two years ago. But my household income is around $300,000.

More reflections on current socioeconomic status and previous settlement patterns are as follows:

> Initially when we came to the country money was an issue. It slowly built up and now we are in a comfortable neighborhood, pretty good neighborhood. But we were in the same type of neighborhood in Louisiana too. So there wasn't much of a change there but a huge change from when I started in New York.

The same respondents discuss their health in a positive fashion. The first respondent said that her health has remained more or less happy as she is contended with her family –

> I've been healthy for, I've never had any recent changes. So I would say I am healthy I've been healthy. There's no change. All inclusive! Socially, family-wise, I'm pretty content and happy. And my health is good so I'm happy. And given my age I am pretty good I don't have any complaints.

Similarly, the second respondent reflects on health as a social institution rather than biological health promotion:

> Health-wise I think how to maintain your health is very subjective. I'm a recently diagnosed diabetic so my parents have a history of diabetes so I knew it would be coming but certainly I would say that having to keep a babysitter so I could go to the gym, I felt culturally that was unacceptable to me. Which is ok in this culture. American culture I see all the time they take care of themselves whereas coming from my culture you take care of your kids and always just keep pushing your needs or personal needs later, and that later never came. You prioritize your family and your work more than you prioritize yourself. And I think based on our culture the cooking, and cooking, and cleaning takes so long, that you're not giving time for other things.

As stated earlier, the research participants in my study have mixed outcomes of self-assessed health. While most of them indicate their physical health as fair to good in their narratives, the attitude towards disease are reflected positively as: "even if not 100%, it is not bad." Overall, my findings show, consistent with much of the literature cited in this study,

health ranges across levels and dimensions. Health possesses micro to macro level characteristics, while is simultaneously expressed through everyday experiences. Health, hence, is a fluid reality that flows through attitude formation to building organizational engagement. Past literature has focused on socioeconomic gradient of health (Barr, 2008), and based on my research findings it is crucial that studies should also focus on the influence of social gradients on health.

CHAPTER 6

DISCUSSION AND CONCLUSION

While the primary goal of this study was to examine the influence of assimilation and discrimination on self-assessed health outcomes among immigrants of Asian origin and paramedics of Asian Indian origin, the study also addressed assimilation measures by gauging the attitudes that minorities have towards the government. This research shows that attitudes towards the government are a useful, important and significant measures of assimilation. In addition, in-group and out-group feelings, also included to measure assimilation, have been found significant. These measures of assimilation are considered non-traditional in the context of sociology, and the objective to incorporate them in this study was to check if they can improve assimilation measures based on sociopolitical perspective. Accordingly, the first research question asks: Are efficacy and common fate strong measures of assimilation? Based on the values of CFA estimations, efficacy and common fate are valid measures of assimilation. This finding is consistent with existing literature, and hence the constituting elements of assimilation are relevant to our improved understanding of the concept.

The first element, efficacy is described as people's perception of powerfulness or powerlessness in the political realm (Morrell, 2003). In similar socio-political and cultural vein, considering human rights issues, common fate asserts group consciousness among minorities, which has traditionally used in the context of inter-racial relations between blacks and whites (Lee, 2008; Chong & Rogers, 2005; Mayeri, 2001) . Linking fate as part of the conscious process is a "key concept in understanding how racial minority groups in the United States

have overcome exclusion, prejudice, and disadvantage to achieve equal rights in the democratic process" (Chong & Rogers 2005, p.1).

The findings from the first research question have major implications for assimilation. Simultaneously, the findings embody a meaningful social construct for the U.S. society overall. Both classical and contemporary assimilation literature have conceptualized immigrants' political incorporation as a basis for achieving human rights. Historically, political efficacy as means to gain rights is widely exemplified in the Civil Rights Movement that resulted in major shifts in the history of race relations in the U.S. Historically, although among minority groups, African Americans' suppression has lessened through the voices of the Civil Rights Movement, no such evidence of a mass movement is apparent in response to suppression that Asians face. It is, therefore, time to incorporate "Not Just Black and White" model as described by Nancy Foner and George Fredrickson's anthology that resonates with gaining more understanding of diversity.

On practical grounds, since the 1960s as "part of ethnic studies agenda established by student activism," Asian American study is gaining institutional recognition (Wong, 1993: p. 3). As is widely known, because of the legality of "one drop rule" and social "desirability of Americanism," on multiple occasions Supreme Court ruling have excluded almost all immigrants of Asian origin systematically (Wong 1993) from gaining citizenship; the only exception to this applied to refugees and immigrants in the wake of Vietnam War. They were differentially labeled at various time frames either being called as Orientals or Asian Americans. Using racial criteria, the 1790 Act of Naturalization limited citizenship to only "free White people" which was challenged on the behalf of Blacks in the Civil War. In the context of non-white citizenship, Asian immigrants became the most significant "other" in

terms of citizenship eligibility (Lesser, 1985). In Supreme Court rulings, in cases such as Ozawa vs. Court, and Thind vs. Court, naturalization was openly denied on the basis of the abominable and pseudo-scientific arguments that races other than "preferable-Whites" are racially different (Kim,1992). In these cases Supreme Court ruled Asians differentially by means of the pseudoscientific evidence. For example, whereas Japanese were denied citizenship considering them as other races, naturalization experiences of Asian Indians illustrate a different story and complicated ruling outcome. As the court ruling of Thind, who was an Asian Indian and self-identified as Caucasian, indicates that despite claiming his ancestry of Aryan race, yet he was ruled out of citizenship by the U.S. court. According to the U.S. court, the reason behind ruling Thind out of citizenship was because of his ancestry which contained "one drop mixture of poor quality blood." This historical court ruling purported "Caucasianism" as a race that fails to hold "pure race" label in true sense. Other reasons that court ruling forwarded were non-assimilability criteria of "other colors" to overrule the naturalization of Thind.

While these stories provide a stronger background to predict a relationship between assimilation and sociopolitical measures, the significant levels of the estimates found in this study established an empirically tested linkage between assimilation, efficacy and common fate. In conclusion, to answer the first research question (H1) efficacy and common fate are strong measures of assimilation. Similarly, the Confirmatory Factor Analysis indexes show that items loaded on discrimination are significant. Overall, the measurement model test indices show that the model fits the data.

The central goal of this study was to test the moderation effect of assimilation and discrimination on social health outcomes. This objective constitutes the central thesis of this exploratory and inferential research. To meet this goal, the second research question posed was:

Whether and how do immigrants of Asian origin, experience and utilize political, social, cultural, economic and/or psychological processes that impede or develop their health condition? Also, to connect the findings from the survey data with subjective oral history narratives, the third research question posed was: How do paramedics of Asian Indian origin, narrate and respond to experiences of immigration, assimilation, discrimination and their health from the onset of decision to immigrate followed by arrival, and post-settlement process in the U.S.? While overall findings from the full model showed that the moderation model fits the data, however, the multiple individual pathways in the model indicated non-significant relationships.

Assimilation, discrimination and outcomes of health

Based on substantive evidence from the past research, it is currently known that assimilation, often interchanged with the definition, over time stay in the U.S., leads to poor outcomes of overall health among immigrants and racial and ethnic minorities (Hummer, Powers Pullum Gossman & Frisbie, 2007; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Singh & Siahpush. 2001; Rogers, Richard, Robert, Hummer, Charles & Nam, 2000). My findings, on the contrary, show that assimilation has no effect on outcomes of health among Asian Americans. Similarly, contrary to the expectations, quantitative findings show that experiences of discrimination have no effect on health among people of Asian origin. Discrimination is defined as differential treatment by the members of a group who hold negative attitudes and beliefs towards racial and ethnic out-groups or "others" (Williams & Mohammed, 2009). On further investigation, the one-sample t-test results show that out of all the forms of discrimination examined in this study, at least one form of discrimination is

experienced by each respondent[40]. Based on qualitative findings, however, I find that a third of eighth (six out of sixteen) respondents or little less than a half have experienced discrimination in some form. Respondents, however, feel reluctant to express their discrimination and internalize the experience as "it is normal", "it is o.k.," "it did not bother me," "they are old patients." The two male physical therapists considered their experiences of discrimination with serious consequences- expressing them as real with ill feelings. This evidence supports the notion that Asian Indian paramedics express resiliency towards negative experiences; in spite of marginalized experiences, self-assessed health described by majority of my respondents is positive.

Consistent with the literature, these findings indicate that because racism is deeply embedded in the culture and institutions, it is likely that discrimination can persist in institutional structures and policies even though the context of individual discrimination may have ceased to exist (Williams & Mohammed 2009). Individuals who experienced discrimination are aware of the fact that some negative behaviors are targeted at them and these perceptions of unfair behaviors create stress (Williams & Mohammed 2009; Pearlin, Schieman, Fazio, & Meersman, 2005). Stress is tied with various physiological ill health outcomes (Epel, Lin, Wilhelm, Wolkowitz, & Cawthon, et al., 2006; Seeman, Crimmins, Huang, Singer Bucur, & Gruenewald et al.,2004). While some paramedics expressed their discontent with their working environment and the treatment that they received from this environment, they also expressed moderate-to-poor health outcomes. The respondents who expressed poor health outcomes are a numerical minority. The results from the quantitative data analyses of discrimination and health indicate that those who experience discrimination are less likely to

[40] To illustrate, in this study one sample t-test examines if discrimination exists- a comparison with baseline model = no discrimination experienced.

identify themselves as American than hyphenated Americans i.e., Asian Americans. Hyphenated identity leads to integration in the American society, which is concurrent with the literature. Accordingly, the experiences of discrimination both restricts and promotes Asianization and Americanization in a "select and assimilate" manner that resonates with the idea in literature labeled as "selective assimilation" (Brown & Bean, 2006) process. By adapting a selective assimilation process immigrants of Asian origin continue to exercise cultural and behavioral habits of the origin and in the process are less likely to victimize themselves of poor health outcomes. As findings from the narratives indicated, during their initial adjustment in their work place, assuming that they could likely to be discriminated, some adapted pro-active assimilation patterns to foster a sense of trust, closeness and common-to-workplace experiences to draw attention from mainstream population consisting Americans of European ancestry or non-Hispanic White Americans, which in turn served as a pre-requisite to healthy living through institutional/structural acceptance.

The unwelcoming attitude towards minorities of color is not uncommon in the U.S. institutions and structure. For example, as the following narrative reflect:

> No they never informed. I said that I don't even know that all these things exist. I went to the committee and asked, and I said I did not know anything. They said you never asked for it. That is what he said, the committee chair said. This is the reason your name is not here. He said, you never volunteer for anything. And emails, they send to only a few people, sending emails to a few people for volunteering opportunity. They never offered anything to me, they never asked me. Recently they sent, mail to all the people, I applied for that. I am volunteering this time.

The propensity to pro-active assimilation pertains to the sociable nature of culture of the origin. Utilization of carrier-of-origin-traits is reproduced in the host society to gain health as opposed to loosing health. For example, according to a retired nurse who worked for 15 years,

[I was a shift worker]
Yeah I have felt, in my work time I have felt because of my race and all that certain things I was not given. But otherwise in general like in restaurants and buying property I don't feel anything like that. **(Probe: Could you be more specific about the workplace?)** Well you know there are certain physicians I believe they would prefer to give to Americans not Asians because of the cultural difference or accent or whatever they may think. It is impossible to handle the workload when there is short staff in relation to patient demand. And the care gets very much regulated. Well the people you worked with were bombarded continuously given the short staff and but then if you don't perform well you are asked "You didn't do it." Well there are 7 or 8 patients and you are all like in pain or need blood or somebody's hemoglobin is going down, you can't give too much time to one person. And there are like 30 people on the floor. How do you take care of them? That's why they are demonstrating in capitol building that the ratio is short of staff, they need to hire more people. It's very complicated, they keep very tight staff because health care has such a good turnover every day.
Initially I thought everyone knew everything except me, so I was a little intimidated but slowly I got over it. And people also treated me [expressed well with a nod] because I was kind of quiet. And slowly I got trained, I got used to it, So, I made tea one day and somebody tasted it and then to make long story short, it was 4 o'clock British team time. People started making cake and zucchini bread. Things started coming, people started bringing tea for me. People used to, doctors used to make a round about 4 o'clock just because of tea. Tea time! It became so popular. Everyone who knows me, [Says her name] makes tea. Then we started this Diwali luncheon which people look forward to. And it started with 50 people in this big conference room and it was the whole hospital, slowly! Like 300 people will come. And people knew me and I really liked later on working, also was in charge of the floor many times. I liked, I thought when people came to know me, we, I really enjoyed it. I meet them several places still.

As this evidence illustrates, the tea making event became an agenda to welcome closeness from others at work place. It was important for this and several other respondents that they first receive welcoming attitude and behavior before starting to deliver work of preferred quality. The gradual formation of liking towards work and timely work delivery for this respondent meant a multiple step-by- step process: first-acceptance, next-development, and finally- a sense of belonging leading to greater emotional/mental health. However, this lengthy social acceptance process did not come through from her work environment at first. At first it was the participant who initiated tea making event while balancing with delivering desired

skill-specific and demand-specific work load. I call this pro-active ethno-initiated assimilation to self-enhance positive health.

The measures of assimilation in this study pertain to sense of belonging and sociopolitical engagement; these are the characteristics that are rarely been used to measure assimilation in any social and public health research. My study's findings show that citizenship status has significant influence on health. Although a majority of Asians have migrated on family reunification provisions[41], as data in the previous chapter showed, Asians are more likely to migrate through the skilled visa category and therefore gain from greater value assigned to legality and socioeconomic status. Contrary to documented or citizenship status, an undocumented status can affect immigrants' health risks in several ways, as expressed in existing literature (Salcido & Adelman, 2004; Hirsch, 2003; Menjı´var, 2006; Menjívar, 2000; Massey,Durand, & Malone, 2002; Guttmacher, 1984). In the context of legality, assimilation of my research participants concentrates on differences between documented and undocumented status rather than on the system of law that governs them. Primarily, the fundamentals of legal entry that shapes their health outcomes during their initial stages of adjustments are the most

[41] "Most Asians came to the United States through family reunification provisions, though refugee or skilled worker movements were often the first link in the migratory chain. According to the United State Census Bureau's 2007 American Community Survey, immigrants from the Philippines (1.70 million) made up the second largest group after Mexico. Indian immigrants (1.50 million) were the third largest group, followed by Chinese immigrants (1.36 million). The mobility of professionals, executives, technicians, and other highly skilled personnel has grown in the last 30 years. This "brain-drain" can mean a serious loss of human capital in medicine, science, engineering, management, and education. Depending on the origin country's labor needs, losing such people can present a major obstacle to development" (Castles & Miller, 2009b). Although historically Asians have entered into the U.S. more in number on family visa, currently, however, most visas are granted to skilled immigrants from Asia. As sated: "Mostly foreign-born and naturalized citizens, their numbers have been boosted by increases in visas granted to specialized workers and to wealthy investors as the U.S. economy becomes driven less by manufacturing and more by technology"(The Associated Press., 2012). Furthermore, according to "Karthick Ramakrishnan, a political science professor at the University of California-Riverside and a fellow at the Woodrow Wilson International Center for Scholars, U.S. immigration is more diverse and broader than that, with policy that needs to focus also on high-skilled workers,[now]With net migration from Mexico… at zero, the role of Asian-Americans has become more important," (cited in The Associated Press., 2012).

critical experiences in shaping self-assessed health. In this study no questions were directly linked to liminal legality, the gray area between black and white of legality (Menjívar, 2006). However, if the experiences of liminal legality are situated on a continuum of legality-to-belonging, I predict that a status of this nature will act as a catalyst to forming a negative influence on 'immigrants' health outcomes. With more data, in my future research I will conduct an empirical study on liminal legality and health outcomes.

Although in this study assimilation shows no influence on health outcomes, civic engagement processes influence health significantly. Concurrent with the evidence from past research, ties to community group membership and the potential moderating role of group membership are critical to the formation of social capital pathways that can lead to increasing access to health messages (Viswanath, Steele & Finnegan Jr, 2006). Given that the the measure used in this study includes an item, "taking part in immigration march,"the measure highlights role of an activist, the individual's sense of belonging, advancing perceived power of agency from within. As an advocate of human rights issues, an activist works through the system to change the system for justice. This assumes distinct goals and skill sets in advancing discourse, as well as a debate in which specific social condition are deemed as a problem. Recent research shows that within the health advocacy domain activism appears in various forms (Dobson, Voyer & Regehr, 2012). More importantly, within the health care, activism has been recognized as professionally competent and responsible practice. Increasingly, activism is evolving as a more structured practice with much coherently framed plans and communication strategies to integrate a social problem process. Rapid technological advancement and the active role of media has characterized activism as fundamental method to gain rights and privileges of the suppressed, despite multiple constraints and odds attached to media. Media has

served as the basic platform for activism in industrially advanced democracies and hence in the process has been producing and reproducing confidence, authority, reliability, and trust in civic engagement endorsed by self-efficacy. Struggling to fit into the frames of assimilation/universalism, dominated by non-Hispanic White and European descents, replacing the particularism of diversity further fosters minority majority relations or Black/ non-Black relations (Yancey, Ericksen & Juliani, 1976) confirming to reductionism. This phenomenon lacks the enrichment of empowerment which is embodied and endorsed by the form of health and well being expressed as "individuals' right." Experts and activists use their knowledge to influence and advance health and well being of individuals, communities, and different populations while in return gain more power, popularity and empowerment across class, gender, race, ethnicity, and other numerous social and demographic indicators thereby establishing a dyadic relationship.

Religious attendance, socialization and health

Previous studies have found that religious practices protect against mortality (Hixon, Gruchow, & Morgan, 1998; Infante, Peran, Martinez, Roldan, Poyatos, R. Ruiz, Garrido, & Garrido, 1998; Idler, & Kasl, 1992). This study found no effect of religious attendance on health. Individual narratives showed a mixed attitude towards religious attendance that indirectly influences health outcomes. Those who actively participate in Hindu temples expressed their feelings toward religious participation. This feeling toward religiosity is expressed as good health outcomes:

> Currently I am spending I would say 40% of my time in worship-related activity. **[Probe: What do you do there?]** All worship-related functions: To organize, coordinate, assign, and make announcements for that [job] belongs to temple's board of trustees. This is my third time being on the board. I get a lot of phone calls from the community about the details, inquiries, and I'm fortunate that people

trust me. People appreciate my accountability about it. And I enjoy it. I conduct for Sunday worship for the last 20 years going on. Which I do. And others I plan and look over also.[**Probe: How does this make you feel?]**I feel great. I feel I could do something to make a difference.

The research participants who practice Hinduism and Sikhism primarily expressed their opinion about religion as behavioral pathway and means to achieve self-development rather than asserting it as a belief system. As past research shows that religious influence can also be indirect, (Hummer, Rogers, Nam, & Ellison, 1999) meaning that there is probably a spurious relationship between religion and health, the quantitative analysis of this research found no influence of religion on health. Following is an another evidence from narrative that illuminates spurious relationship between religious participation and health.

[**Researcher: Describe how actively you participate in a place of worship.]**
Not as actively as I would like to. I would like to get more involved and get the kids more involved. When I was in school, I went to a Sikh school, so I used to sing Shabbat I use to play harmonium and I have plans that my kids and I are going to sing Shabbat pretty soon, if not this January then probably by next December and planning to have all three of us get more involved. We do it every year during Vaisakhi, we have the parade, always participate in that. Again, it's not for me, it's not cultural. If I can contribute to a food bank, it doesn't matter who it's by, if it's for a kid's school that somebody dropped off, recently MSU hockey students dropped off their bags for the food drive, but it doesn't matter to me where it's coming from as long as I'm able to help. It's not specifically that I would say hey this is my community and this is the only place that I'm going to support. You go to a grocery store and you can buy 2 cans for yourself and 2 cans for somebody else. It's not me saying, look what my culture is doing and doing for you. I don't have that attitude. There's some patients of mine, and I'm very religious minded, I hated when my patients say to live a life as being a Christian. I sometimes, would rather say hey my religion is not worse than yours.[**Probe: Do they know you are not a christian?]** Yeah. They do know that and then I politely tell them well what does your religion say? Does it say there is one God? They say yeah, that's exactly what my religion says. And then I love that quote by Rumi, one of the poets, there are a million ways to kneel and kiss the ground. So if it's somebody I'm having a good conversation with I might go and explain myself, why I feel and how I feel. And sometimes they're accepting and sometimes they're not. Sometimes they still say hey, the only way is through Jesus. I think, well that's your narrow-mindedness, I respect your religion and I'd hope you respect mine

This story indicates that religious attendance is grounded in practicing-religion, such as giving services to others, attachment, closeness, and fostering healthy thoughts. Accordingly, among respondents, the mentality of providing service to others is independent from the confinements of religious faiths. The meaning behind giving service or the ability to provide help is more likely to influence health and healthy outcomes rather than reading religious scripts. Based on this narrative, the relationship between religious attendance and health draws insights and meanings from social construction, thereby rejecting reductionism. This shows that community service is more important even for high skilled immigrants than the practice of religiously driven goals. However, religion acts as a catalyst in promoting helping attitude.

This research does not find any relationship between preferred socialization practices and health outcomes. Spending time with family, friends, at work or something else did not have a significant effect on health. Health is randomly distributed across these categories and no one category dominates over the other. Based on the narratives, socialization preferences are found to have mixed outcomes. While more number of paramedics prefers to spend time with family and friends, a few others mentioned pursuing hobbies or simply spending time with the oneself. However, the time spent in other family socialization is mostly found among married couples and those who are single. Families with children indicate spending more time with family and friends. In this study the lack of any influence over health is a probable indicator of the assumption that different forms of socialization have a discreet existence in the context of health. Illuminated by the narratives of paramedics, it is very likely that health is understood by the health care professionals primarily as a biological determinant rather than social. Similar explanations can be extended to other Asians in relations to how view towards health differs due to the cultural variations. For example, as an evidence from a respondent exemplifies:

> Well…I think in a lot of ways it made me feel like…the culture is like so self-involved. It's such a narrow world view, the U.S. culture. Because when I meet…I kind of find myself reaching out to others, but I see that harder for me to [stops to breadth]..well, Asian Indian or another person that's not American, I tend to go talk to that person first. Because I'm interested in meeting people from other cultures and I think that…and this is a very…this is a broad generalization but I think largely that Americans tend to focus on themselves as opposed to…and particularly teaching their children to focus only on themselves as opposed to learning about other cultures and maybe trying to understand other cultures better and make other cultures feel more welcome into…into the United States.

The example provided above is an illustration of the rigidity, compartmentalization, and stiffness that the U.S. culture broadly depicts and consequently restricts socialization from "alikeness"-to- "otherness" or social closeness-to-social distance. Evidence from narratives show health is primarily understood as biology rather than various social forms among nurse practitioners including the respondents who grew up and received graduate nursing training in the U.S. In this context, by going over and beyond of Hispanic health paradox, the overall fair--to-good health results from this research initiates the need for a broader discourse on race and ethnic health paradox. Use of the words in narratives such as genetics, exercise, "I should do more work" indicate that a sociobiological model of health in health related empirical research should carry considerable importance (*see* Brunner, 2000) in sociology, similar to social determinants of health.

Conclusion, limitations and future direction

This research shows that diverse religious practices, community engagement, secured legal status, and financial advancement are primary indicators of nurturing good health. The quantitative data analyses show that these findings are significant. These determinants are self explanatory to the advantages and values that they bring in a society. This research also provides evidence of multidimensional characteristics of health when explained by the

influence of social factors included in the study, hence forming a dyadic relationship between social determinants and health. As a basic means of sustenance, the meaning behind promoting health and well-being is to serve fundamental human rights. This research also informs migration while tying it to race and ethnic health scholarship. Understanding the experiences of health care workers contributes to the growth of human resource, larger economy, and the most debatable system in the U.S.: the health care.

Although evidence from past research depicts that racialized experiences among racial and ethnic minorities and immigrants of color is declining, such dilution due to the presence of natvist sentiments is hard to achieve. Based on the t-test, this research shows that experiences of discrimination are real and experienced in some or the other forms by the respondents included in the study. Similar findings are not uncommon in narratives. As compartmentalized as the U.S. society is, where color and class ad-mixture has been consciously avoided and often times denied, it might be a life and death issue in the current environment to ignore diversity in health. Along this line, while it is clear that active discourse and data gathering efforts on individual's health, health care, and well-being are consistent, it is an irony that in a most industrially advanced nation, such as the U.S., health care lacks universal access, which sends out a subtle message that health is "not for all." Ironically, health care is a basic and everyday necessity, as evident in my research, and it is yet a complex, costly, and non universal fact. Although this fact is non-concurrent with moderate level of racial and ethnic health paradox found in my sample paramedics, the social experiences at the intersection of race, ethnicity and socioeconomic status also manifest a complex relationship for my sample.

Theoretically, this research shows that at the macro level structural formation of nation-states by means of different social forces, such as citizenship has reinforced racialized

treatments. Similarly, another macro phase interaction between individual and institutions in everyday life exposes minorities to racialized expressions. Attitudes of nativist sentiment perpetuate such racialized treatments at the micro level leading to formation of a continuum at the intersection; however it must be noted that the levels including the phenomenon are not mutually exclusive. Hence, the influence of this complicated matrix between levels and phenomenon is complex and diverse on the outcomes of health, the associated paradox being one of them.

Social change enquiries because of racialized experiences demand voices and policy transformation at the intersection of migration, race, ethnicity and structure. This research is a stepping- in into the policy-making process on health and health care, as well as to the voices that find space through experiences, research, knowledge and movement. In a democracy, policy making should be understood as a continuous process, in which initial stages of implementation should keep openings for feedback and reproduction while striving to achieve effective outcomes. Furthermore, keeping various contexts in view, policy making should be flexible in its construction to space, time and culture; all three are crucial to consider when assessing health care.

Although this research shows non-significance of discrimination and health relationship for Asian Americans and individuals of Asian ancestry in the U.S., it is very likely that the current trend of selective migration is dominantly affecting Asian immigrants' outcomes of health. Along this thought, the model minority stereotype about Asians produces a ripple effect of "Asian health model" which ignores robust experiences of stress, hardships and difficulties that Asian health endures and camouflages poor health outcomes with limited number of

hospital visits, which is socially desired (Gee,Ro, Shariff-Marco,& Chae, 2009).[42]In this context, consideration of cause-specific health outcomes should direct future research.

There are some limitations to the data. This research had two primary purposes. First, the research intended to examine if immigrants and minority health paradox, such as Hispanic health paradox exists among Asians. Comparative research on Asian health outcomes with other racial and ethnic groups consistently show that Asian experience positive health outcomes (Singh & Siahpush, 2002). Rarely, however, have race and ethnic studies on health and well-being measured experiences of discrimination and its influence on Asian health outcomes. While a study domain such as this is likely to expand knowledge on the health paradox, due to the lack of data on non-Hispanic White health outcomes, a comparative research of self-assessed health, health paradox, and discrimination and health using NAAS 2008 data is limited. Therefore, to meet this challenge, in this study, the researcher used a baseline model comparison to understand the discrimination effect and influence on health within the group. A more insightful study could be developed using data from the non-Hispanic White population.

The NAAS 2008 does not provide information on cause-specific health outcomes. This means that NAAS 2008 is restricted to investigating health outcomes based on global health question. The global health question, however, is advantageous to the use of phenomenology, in which social construction of health is meaningful by the use of global self-assessment of health. Also, the data set has almost 90% of data missing on the discrimination variable for foreign born Asians. This restricts investigation of health outcomes among foreign born Asians. To examine this data with a reliable sample, the data from native born Asians should be

[42] According to Gee and colleagues, Asian Americans are likely to avoid expressing their experiences with discrimination in their tendency to "present oneself favorably, to avoid ''losing face'' or shaming oneself or their families, which is called social desirability.

combined with data from foreign born Asians. In the future I would like to examine the outcomes of health by nativity. I would also like to explore and examine the outcomes of cause-specific health among Asians and Asian Indian paramedics and physicians with a larger sample size. Another social indicator that this research did not incorporate was gender. For future research, I would like to understand the influence of gendered assimilation and discrimination on the outcomes of health among Asian Indian paramedics or physicians alike.

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