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BORDERS AND BARRIERS: PERSPECTIVES ON AGING AND ALTERNATIVE  
MEDICINE AMONG TRANSNATIONAL NORTH INDIAN IMMIGRANTS

by

KANAN MEHTA

Under the Direction of Cassandra White

ABSTRACT

This study explores the practice of alternative medicine among a group of senior, transnational Indian immigrants. I analyze how cross-cultural ideologies influence aging and immigrant experiences in healthcare. I explore the ways in which transnational networks nurture social relations and aid in acquiring healthcare resources. This study also examines the developments that alternative medicine underwent during the colonial rule and how those developments affected the trajectory of biomedicine. I focus on the practice of alternative medicine as a significant contributor to immigrant health. Finally, I argue that we need to strive for a symbiosis between alternative medicine and Western biomedicine based on multicultural sensibilities and socio-economic factors that call for a pluralistic medical system in a globalized world.

INDEX WORDS: Aging, Indian, Immigrants, Immigration, Ayurveda, Colonialism, Western, Medicine, Senior, Culture

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MEDICINE AMONG TRANSNATIONAL NORTH INDIAN IMMIGRANTS

by

KANAN MEHTA

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2010

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Kanan Mehta

2010

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Georgia State University

December 2010

## DEDICATION

To Mom, Dad, Anand and all the participants who made this study possible.

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## CHAPTER 1

### INTRODUCTION

My interest for examining the applications of alternative medicine arise from my early exposure to alternative medical systems in my childhood. I come from a family of Ayurvedic practitioners and biomedicine physicians. My paternal grandfather was an Ayurvedic practitioner and my maternal grandfather was a physician. Hence, my parents came from two distinct schools of medicine believing in two different ideologies of health. I have seen my father believe and adopt alternative medicine throughout his life. Therefore, my awareness of a pluralistic medical system challenged the idea of exact science or a singular “true” medicine system. Moreover, my immigration to the United States and my positioning as an only child of two aging parents have shaped the motivation for this study. Through this study, I explore the practice of alternative medicine on the part of a group of senior Indian immigrants. Additionally, I examine the role that transnational networks play in immigrant health and social relations.

#### *Immigration: a Social and Legal Perspective:*

According to Talwar (2003: 4), the immigrant population has tripled within the United States following a relaxed policy on immigration since 1965. Moreover, in 1986, immigration was allowed to the United States based on lotteries and family sponsorships, inviting migrants with skills that were not necessarily being sought in the American job market (Kalita 2003: 11). Hence, based on Kalita’s findings, even though many Indian immigrants immigrate as educated professionals, this is not necessarily true of all migrants. The changes in immigration-related policies have led to an increased influx of Indian immigrants in the United States. Thus, Indian immigrants have been a significant part of American demographics for decades, coming from a

diverse array of regional backgrounds. Their presence is especially evident in Atlanta, considering the emergence of cultural associations, places of worship, and local radio and cable channels. Asian Indians are demographically present throughout Atlanta but are heavily concentrated in Fulton (4200), Gwinnett (6600), Dekalb (4700) and Cobb (3800) counties. As per the 2000 data on labor, Atlanta's businesses that require an expertise in IT (Information Technology) have been a source of professional attraction for many Asian Indians. Apart from this, most of the Asian Indians are employed as physicians, surgeons and in other occupations such as business, finance and management (Atlanta Regional Commission 2009).

Furthermore, Atlanta has multiple Indian shopping complexes. The Global Mall is an Indian shopping mall that is situated on Jimmy Carter Boulevard. An Indian cinema theater called Galaxy cinema is also situated in the same vicinity. In my experience, Asian Indians find the Atlanta climate to be more pleasant as opposed to other United States regions that witness heavy snowfall or an extremely dry, arid climate. This coupled with a low living cost as opposed to other places that have a high turn-over of IT professionals such as the Silicon Valley in California, make the Atlanta metropolitan region attractive as a target region for immigration.

With regard to immigrant experiences, Said's analysis of an exile's psyche parallels the immigrant's state of mind. Said states that an exile is not isolated from his/her place of origin but rather carries it to their host country (Said 2010: 647). From my own experience, I feel that the process of adaptation to a new culture is often traumatic, uncomfortable and intimidating for most immigrants. Quite often, they find themselves at a foreign threshold, with wistful memories of a world that they have left behind. Personal possessions, such as jewellery and heirlooms contribute to the reconstruction of identity in the host country. The preservation of these articles perpetuates the feelings of returning to the native country and are considered more significant in

maintaining “Indianness,” than the continuation of other traditional patterns, such as meat consumption or the observance of religious occasions, in some cases (Belk and Mehta 1991: 398).

Furthermore, this transition entails navigating through everyday life, dealing with the everyday pressures of the new host country. Immigrants seeking medical care have to navigate their way through structural inequalities and bureaucratic procedures that are foreign to them (Chavez et al 2003: 197). Furthermore, many of these younger immigrants face the responsibility of caring for the elderly in their family given the conventional social norms where the state does not provide supplemental security income such as the case in the United States (Lamb 2002: 311).

#### *The Social Constructs of Aging: Age as Category vs. Age as Fact*

Past research has emphasized the notion that the discourse on aging does not take in to account age as a separate category that requires observation and analysis. Age is not included as a relevant social category such as race, caste, religion and gender in the study of the socio-cultural world (Lamb 2000: 8). In addition, popular culture and the Western medical system equate aging with disease to an extent that the difference between normal physiological changes and the prognosis of a disease is lost. For example, depression is sometimes attributed to aging instead of it being evaluated as a medical disorder. This leads to negligence in treatment of significant conditions since illness is considered to be the equivalent of aging (Kaufman 2009: 431). Hence, depression is either dismissed as a condition of old age or is viewed exclusively as a medical condition overlooking the social life of the individual. Similarly Becker and Kaufman (2009: 168) suggest that since aging is often equated with illness and dysfunction, the cultural

attitudes about aging are significant players in comprehending illness from both the physician and the patient's perspective.

Also, these interpretations of illness become institutionalized in the healthcare system through the applications of biomedicine and policies. For example, a "motivated" patient is defined as an individual who "complies" with all protocols regarding treatment and actively engages in his or her own self-care. This also implies staying positive and sticking to the framework of recommended treatment irrespective of feelings of frustration or pain that a patient may experience during the period of treatment (Becker and Kaufman 2009: 169). These expectations place the burden of recovery on the patient. Hence, the failure to recover may result in self-blame and guilt for one's condition and increased feelings of isolation and stress.

However, this deficit model of aging has given way to a more empowered aging process in the late 20<sup>th</sup> and early 21<sup>st</sup> centuries. Authors Byrnes and Dillaway (2009) challenge the paradigm for "successful aging" that defines a successfully aging individual as someone who exhibits particular physiological and cognitive traits. For instance, the model for "successful aging" includes a person who does not smoke, is not hypertensive and has a body mass index of less than 30 percent over time. Also such an individual shows the absence or low risk of heart disease, cancer, osteoporosis, diabetes, stroke etc (Byrnes and Dillaway (2009: 705). The authors are critical of these standards of "successful aging" citing that these standards posit aging in a limited context that does not consider aging as a multidimensional, enriching process but as something that can be measured in terms of success or failure (Byrnes and Dillaway 2009: 706).

Other studies are reflective about the positive associations with the aging process that includes opportunities for empowerment and self expression. For example, according to a study on Iranian Americans, even though immigration to the United States entails loss of socially

cohesive ties, yet, the American setting also offers the possibility of exploration, recreation and self development which are being pursued by many senior groups. (Hegland & Associates 2009: 304). The seniors in this study participated in Persian and ballroom dancing, Persian poetry recitals, English classes and active engagement in serving their community (Hegland & Associates 2009: 311). Thus, senior immigrants are able to explore new venues of cultural expression on one hand, and transcend the cultural perceptions of aging in the native society on the other hand. Therefore, immigrants populations often redefine cultural notions of aging when they redefine cultural boundaries.

#### *A Word on Transnationalism*

Lamb defines the term “transnational” as “social, cultural, political and economic forces that extend across two or more nations” (Lamb 2002: 303). Transnational immigrants are also seen as forging and maintaining social, political, economic and cultural ties across international borders and thus the native and the international domain become territories of social action (Lamb 2002: 303). Therefore, immigrants travelling between the United States and India also transport cultural beliefs and practices to both countries. She further identifies two criteria of transnational living. The first criteria is periodic and consistent travel between two countries which entails dual citizenships, residences, bank accounts and spending time with family and friends in the host country (Lamb 2002: 304). The second criteria is less tangible but profound and that is negotiating two cultural worlds while residing in one geographic location (Lamb 2002: 304). This may include merging the Indian and the American cuisine such as grilling vegetables and meat in spices for barbeques. The senior immigrants aptly fit this description consisting of individuals who either travel from India to visit their children in the United States

or who themselves stay in the United States but maintain transnational ties. Either way, there is extensive travel involved between the host country and the native country respectively.

For the purpose of this research, I am grouping Indian immigrants into three categories. Most of the immigrants arriving in the United States were engineers, scientists and physicians who immigrated in considerable numbers between 1966 and 1977. These were the early immigrants (Bhattacharya & Shibusawa 2009: 449). The older first generation immigrants arrived on the sponsorship of their adult children (Bhattacharya & Shibusawa 2009: 450). In addition, there are senior Indian immigrants who stay intermittently with their children instead of on a permanent basis as I have come across in this study. Irrespective of the time at which these immigrants arrived, they all maintain cultural ties in India and the United States.

Considering the changes brought on by globalization and policy, I have outlined the developments in immigration policy that led to an increase in immigration to the United States among Indian immigrants. In addition, I have put forth the cultural attitudes that posit aging in culture and policy making in chapter one. Chapter two highlights the cross cultural perspectives on aging and their role in shaping immigrant perspectives of health. Chapter three outlines research methodology, ethical guidelines and the limitations of the study. Chapter four posits immigrant experiences with regard to illness and treatment based on their experiences in the United States healthcare settings. Moreover, this section explores the notions of health and illness among senior Indian immigrants in this study.

In addition, I discuss the transition that alternative medicine in India underwent under colonialism and how it has affected the perceptions and practices of alternative medicine at present. In general, alternative medicine refers to the use of therapies that substitute biomedicine and complementary medicine (Baer 2008: 404). Chapter five puts forth the interrelationship

between contemporary alternative medicine practices and how they tie in with globalization and immigration. For example, Quinlan (2008: 170) notes that 70 per cent of the world's population primarily utilizes traditional herbal medications. However, they also observe that urbanization mostly has an adverse effect on the knowledge and practice of traditional medicine as noted in the evaluation of development projects in Western Mexico. Moreover, the diminishing of traditional knowledge may cause a shift in healthcare seeking behavior. In addition, this segment highlights the changes in the traditional family system and the experiences of aging brought on by globalization and their implications on transnational networks. Chapter six explores the interconnectedness of transnational networks and immigrant access to healthcare resources. Furthermore, I discuss the role of policy and community intervention in bridging the gap between alternative medicine and Western biomedicine, thereby benefitting immigrant health. Thus, the objective of this study is to examine the multifaceted processes involving transnational immigration and applications of alternative medicine.

## CHAPTER 2

### THEORETICAL FRAMEWORK

#### *Cross Cultural Constructs of Wellness*

As Chavez notes, cultures cross borders along with immigrants (Chavez et. al 2003: 199). Naturally, issues arise from the confrontation of immigrants' cultural beliefs with the host country's medical system, such as in communities that may be stigmatized due to a particular disease, besides structural obstacles (Chavez et. al 2003: 198). Immigrants import values, behaviors, beliefs and their own cultural assumptions about what it means to be healthy that may not necessarily be in accordance with the host societies' cultural realities at large (Chavez et. al 2003: 200). According to Geertz, a cultural system has the "capacity to express the nature of the world and to shape that world to its dimensions" (Geertz in Chavez et al 2003: 200).

Additionally, Chavez states that anthropologists have viewed biomedicine as a cultural system similar to other religious and ideological systems as biomedicine fits into the definition put forth by Geertz (Geertz 2003: 200). In other words, "hard" sciences are seen as more serious sciences among various segments of both western and non-western societies. The concept of objectivity is valued whereas social scientists have long established that how a result is interpreted is not free from the researcher's own standpoint. Therefore, biomedicine as a discipline is as much embedded in a socio-political context as any other discipline bringing us back to Geertz's description of a cultural system. Hence, the overall notions of health and illness are constructed and reconditioned among the masses and the medical community arising from

the epistemological foundations of biomedicine. Therefore, it is necessary to acknowledge different cultural models of disease and illness.

However, it is necessary to differentiate between disease and illness before we delve into the cross-cultural constructs of various health models. According to Kleinman, illness represents the internal experience of an individual's suffering and symptoms. It encompasses an individual's family and broader social network, and their perception of and response to his/her disability or symptoms (Kleinman 1988: 3). However, disease is a problem from the practitioner's point of view. It is what the physician has been trained to see through the theoretical paradigm of their practice (Kleinman 1998: 5). Similarly, as per Brown,

Disease refers to observable, organic, and pathological abnormalities in organs and systems whether or not they are culturally recognized. On the other hand, illness refers to a person's perceptions and lived experience of being sick or "diseased" - that is socially disvalued states including (but not limited) to disease (Brown 1998: 108).

For instance, a person diagnosed with lung cancer disease would experience his "illness" based on stigma associated with smoking irrespective of whether he/she smokes or not. Brown further asserts that disease is considered a biological phenomenon while illness includes psychological and social aspects (Brown 1998: 108). This distinction between disease and illness also factors into the mind-body dichotomy between Western and non-Western societies. This split is still ongoing even though critical medical anthropologists have criticized this distinction because of its suggestion of a superior "culture-free" biomedical model (Brown 1998: 108). Because of this critical engagement, medical anthropologists emphasize, "all cultures have medical systems that take into account cognitive and behavioral components; and that biomedicine is an ethno medicine of Western culture (Brown 1998: 108)." For differentiating between variations

concerning cross-cultural medical systems, Foster proposes the utility of naturalistic and personalistic ethno medical systems (Foster 1998: 110) as they are related to beliefs about causality/etiology of illness. As per Foster, “naturalistic systems have etiologic explanations that are usually restricted to symptoms and a single level of causality. Hence, naturalistic cures are generally oriented toward the physical body (Foster 1998: 110).” Naturalistic systems attribute illness to changes in body balance or equilibrium and are also known as humoral systems or models of health. On the other hand, personalistic systems provide etiological explanations that include social relations. Consequently, cure is sought for the illness such as witchcraft as well as the underlying social causes that played a role in causing it (Foster 1998: 110). However, medical systems or cultures do not necessarily fit neatly into these broad categories created by Foster, but they are useful models for looking at etiological beliefs.

Similarly, Scheper-Hughes and Lock (1987) assert that the conceptions of the body are not only central to shaping research and theoretical paradigms in medical anthropology but also influence healthcare planning. The authors put forth three perspectives with regard to how the body is viewed:

(1) as a phenomenally experienced individual body-self; (2) as a social body, a natural symbol for thinking about relationships among nature, society, and culture and (3) as a body politic, an artifact of social and political control (Scheper-Hughes and Lock 1987: 6).

These three viewpoints represent both Western and non-Western perceptions of the body as an individual and social entity bound by social dogma in which individuals negotiate their individual/social identities within the confines of cultural norms. With regard to cultural medical systems, this study takes into account the medicine systems of Ayurveda and Homeopathy. Both systems are humoral in nature and would be “naturalistic” systems, using Foster’s terminology. Also, Ayurveda and Homeopathy have been prevalent in India on an almost equal footing:

*Ayurveda:*

The practice of Ayurvedic medicine dates back at least 2000 years in South Asia (Smith and Wujastyk 2008: 1). According to Ayurvedic principles, human beings are part of a biological system that consists of three life forces: *kapha*, *pitta* and *vata*. Each life force is further composed of one or two of the five elements of the universe that are ether, air, fire, water and earth. The aforementioned life forces are responsible for the physiological and psychological state of an organism. The imbalance between these life forces manifests as a symptom of disease (Patwardhan et al 2005: 2). The main distinction between Western biomedicine and Ayurveda is that the psychological and somatic aspects of illness are integrated in Ayurveda, while this is not necessarily the case in Western biomedicine (Langford 1995: 330). Ayurveda has been known to offer holistic solutions not only as an alternative medical system for patients, but is also of immense value to scholars when seen from the prism of history and as an ongoing practice.

*Homeopathy:*

Homeopathy is known to be developed by the German physician Samuel Hahnemann in the early 19<sup>th</sup> century. Homeopathic treatment functions on the notion that the body's immune system can be stimulated into defense by producing the same symptoms as the disease itself. Therefore, as part of diagnosis and treatment, patients are given medicines derived from plant, animal and mineral sources that imitate the symptoms of the preexisting condition. Homeopathy functions on three main principles. First, the human body operates on the basis of a dynamic equilibrium and the upsetting of that equilibrium manifests as sickness. Second, every patient's condition is unique and the prescribed medication should be compatible with the patient's personality. Third, homeopathic treatment is considered particularly useful to chronic conditions where western medicine and homeopathic treatment complement each other (Whiteford 1999:

71). As per Whiteford, homeopathic medicine is designed to be holistic in its approach where the focus is placed on the person as a “whole.” Hence, two people with the same condition would be treated differently based on their personalities and life experiences (Whiteford 1999: 76).

Both Ayurveda and Homeopathy have undergone changes under British imperialism and gradual urbanization. Even though Homeopathy arrived in the Indian subcontinent in early to mid-1800s, it did not garner legislative support until the late 1940s. Presently, Ayurveda and Homeopathy are practiced widely in India with, for example, 73 percent of Indians employing Ayurveda and 72 percent using Homeopathy for arthritis (Agarwal et al 2007: 237). In addition, Aurvedic medicine suffered a setback under the colonial rule. However, a revivalist ideology coupled with the advertising by Ayurvedic drug manufacturers has rendered Ayurveda in a more commoditized form in the present times (Islam 2010: 781). Thus, it is imperative to consider the place of Ayurveda in pre-colonial and contemporary context when critically evaluating the applications of alternative medicine.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### *Introduction*

According to Karen O' Reilly, "ethnography at least in its minimum definition is iterative-inductive research that evolves in design through the study, drawing on a family of methods, involving direct and sustained contact with human agents, within the context of their daily lives and cultures (O'Reilly 2005: 3). Hence, an ethnography usually involves the challenging task of conceptualizing and studying an evolving set of socio-cultural phenomena, that is complex, abstract and embedded in cultural meaning systems. Therefore, such research calls for qualitative analysis that employs data collection techniques such as in-depth interviewing and participant observation given the involvement of human subjects. This study was conducted among participants from the Indian community residing in areas of suburban and metropolitan Atlanta.

For this research, I interviewed five participants who identified themselves as senior Indian immigrants from North India. The interviewees were selected through snowball sampling. As Bernard states (2006: 193)The snowball technique is used to locate one or two key participants in the population of interest who then recommend additional participants. However, snowball sampling does not represent a random sample that is representative of a large population (Bernard 2006: 193). Therefore, this study may not reflect a uniform application of alternative medicine across the board among all segments of senior Indians in the United States.

The participants consist of three men and two women falling into the age range of 66-81 years of age. Here I provide a brief overview of the participants' background. The names that appear below are pseudonyms.

**Rahul:** Rahul is an 81 year old married man who resides with his daughter in the United States when he visits from India. Rahul holds considerable knowledge about Ayurvedic medicine because his father was an Ayurvedic practitioner. His brother is also an Ayurvedic practitioner in India whom he consults occasionally when he is in the United States. Rahul has both Medicare and Medicaid. He has arthritis and is pre-diabetic. Rahul takes biomedicine and Ayurvedic medicine for his arthritis. He has taken Ayurvedic medicine for psoriasis and Homeopathic medicine for piles. Rahul has a close social network in the United States consisting of friends. Rahul enjoys gardening and writing.

**Bharti:** Bharti is a 75 year old married woman married to Rahul. Bharti's father was a physician trained in Western biomedicine. She was not familiar with alternative medicine and came to know about Ayurveda from a colleague upon being diagnosed with jaundice. Bharti has cardiac disease. She takes Ayurvedic medicine along with biomedicine for her heart. Bharti has extended family and friends residing in the United States.

**Thakur:** Thakur is a 64 year old married man who resides with his spouse in a subsidized senior housing apartment. He and his wife Krishna have four children, one son and three daughters. Their son and one of their daughters reside in the United States while one daughter is in Nairobi and one in India. Thakur possesses extensive knowledge about plants because of his educational background. He has diabetes, hypertension, enlarged prostate and diabetes. Thakur has taken Ayurvedic medicine along with biomedicine. Thakur does not have any extended family in the United States. Thakur enjoys gardening and writing.

**Krishna:** Krishna is a 63 year old woman married to Thakur. Her father was a homeopathic practitioner. She has sciatica, hypertension and arthritis. Krishna has taken Homeopathic medicine for gastric pain. Krishna likes gardening.

**Raj:** Raj is a 66 year old man. He currently resides with his wife in metropolitan Atlanta. He has two children, a son and a daughter. His son does not reside in the United States while his daughter lives in the United States but not in Atlanta. His father was an Ayurvedic practitioner. He has asthma and Type 2 diabetes. Raj has taken Ayurvedic medicine for issues related to digestion. His wife has taken Ayurvedic medicine for chronic cough.

## *Methods*

Here I put forth the following methods that were relevant to my research. For this study, I have incorporated in-depth, open-ended semi-structured interviews. This style of interviewing allows the researcher to probe information in detail and frame further queries based on the interviewee's answers versus asking close-ended survey style questions. In addition, cognition plays a vital role in the process of qualitative interviewing, and hence observance of body language and other behaviors is primarily possible through personal interaction possible through in-depth interviews. Moreover, I feel that one on one interviewing provides the possibility for clarification of responses and modification of research questions when necessary unlike surveys that are more useful in the case of gathering data from larger populations. Furthermore, O' Reilly states that closed questioning keeps a participant from answering freely. In addition, the researcher might not be able to obtain a range of thoughts or reflections on the issue (O'Reilly 2005: 120). Thus, in-depth, open-ended interviewing is a feasible method for obtaining data that concerns sensitive issues such as health and cultural beliefs.

Additionally, as part of participant observation, I accessed local Indian periodicals and newspapers, which publish community event updates and articles. I attended social events where community members confer on a regular basis for socializing and cultural occasions. I also visited Indian grocery stores and American stores/ pharmacies frequented by the participants. Several Indian stores in the Atlanta metropolitan area carry Ayurvedic and other herbal medicines. Apart from over the counter medications for digestion, these stores also stock medications that are available through prescription.

Moreover, I have conducted oral and life history interviews for comprehensive data collection. Life history interviews are pertinent to providing detailed information on medical

history, kinship ties and social/ matrimonial practices. Also, they are extremely useful in cases where there is minimal published data regarding a particular cultural group. Furthermore, the life history method is suitable for ethnographic research because it fosters a rapport between the interview and the interviewee that shorter interviews may not be able to do so (O'Reilly 2005: 128). Oral history interviews are generally more focused on a specific part of an individual's life. Oral history interviews are known to provide voices to minorities, and are even considered a form of therapy (O'Reilly 2005: 128). These interviews were conducted at the participants' residence. In addition, I attended social gatherings with the participants' permission. These social events consisted of potlucks, picnics and cultural celebrations. Out of these, the potlucks and cultural occasions were organized at participants' homes.

### *Ethics*

John Willigen describes the role of an anthropologist as a research analyst, an advocate and a cultural broker. According to Willigen, a research analyst interprets research results for decision makers. As an advocate, an anthropologist supports community groups and individuals. Lastly, an anthropologist forms a medium of communication between policy makers and the communities that are influenced by those policies (Willigen 2002: 5). Hence, the multiple roles played by an anthropologist posit immense social and moral responsibility. Therefore, a researcher is responsible for safeguarding the privacy of the participants. For this purpose, I have ascribed pseudonyms to my participants.

In addition, I obtained their complete consent before I share any of their personal information in my research. As Fluehr-Lobban notes (1994:1), informed consent in anthropological research not only encourages greater openness and disclosure on part of the researchers, but also facilitates a more collaborative relationship between the researcher, and the

researched. Furthermore, Nader (1969) emphasizes the following criteria for effective communication between an ethnographer, and the community members who are being studied: physical proximity of the ethnographer to the people he is studying, knowledge of their language and psychological involvement (Nader 1969: 304). Robert Trotter and Jean Schensul stress building and employing testable, ethnographic theory, for the selection of research methods, as theories and methods are bound together (Trotter and Schensul 1998: 696). This calls for evaluating the impact of a researcher's positioning in the field of inquiry. An ethnographer's positioning plays a substantial role in gaining cultural access and devising the ethnographic framework.

In this respect, I recognize the implications and challenges of conducting this study as a native of this culture. My social standing in terms of my gender and nationality/ethnicity might influence my informants' responses. Therefore, I have attempted to establish a comfort zone with my informants before beginning the research study. I have employed life history and the oral history methods as a coping strategy for gathering information that a participant may evade during personal interviews aside from probing techniques.

#### *Limitations of the Study*

I understand that there are no concrete definitions of an "insider" or an "outsider" anthropologist. Ethnographers often switch and perform multiple identities during the course of their study. Indeed, ethnographers themselves are positioned involuntarily in their environment of study. The discourse between an ethnographer and his/her informants unfolds in two ways. It is a mutual exchange where the ethnographer interprets his/her culture of study, and it in turn moulds him/her as per the native cultural dynamics in operation. This has especially been evident from Kondo's study of the Japanese factory workers in Tokyo. Kondo had to walk a fine line as

a Japanese American female researcher in Tokyo between her American upbringing and the local expectations of acting more “Japanese” during her fieldwork in Japan (Kondo 1990: 23).

In addition, four participants spoke intermittently in English and Hindi, a language spoken widely in North India while one participant spoke only in Hindi. Thus, I may have not been able to convey the exact interpretation of all participant data since interpretation of a foreign language has its challenges. As Corbin and Strauss (1998: 49) note, “words can mean differently from one language to another and from one situation to another.”

Moreover, there is a possibility that I may have overlooked information that I found to be culturally familiar due to my shared cultural background with the participants. Also, I am aware that it may not be possible to make broad generalizations, based on a small-scale study such as this. However, the sample size has allowed me to gain a more in-depth perspective on the participants’ experiences. Moreover, this study does not explore the dynamic between gender, aging and use of alternative medicine due to lack of substantial data at this point. However, I see this study as a project in progress, an opportunity to study the issues at hand more closely in future.

## CHAPTER 4

### DISEASE AND ILLNESS: THE IMMIGRANT NARRATIVES

#### *Spirits, Germs and the Public Sphere*

It is common for immigrants to find certain aspects of their culture in contradiction with particular cultural beliefs of the host country because of diverse and opposing cultural meaning systems. People all over the world tend to develop a larger sense of solidarity with their native culture, and hence harbor strong attachments to their socio-cultural beliefs. Hence, there are cases where immigrants might be viewed as uncooperative because of their resistance toward a set of practices in the host country (Chavez et. al 2003: 201). The health management system and the medical community are no exception. However, it is extremely important to not overlook socio-economic standing or other structural barriers that sometimes play a greater role in how people comply and do not comply with treatment than shifting the responsibility exclusively on native cultural ideologies about health. This implies that people are willing to undergo treatment only if they can afford it, so the cultural beliefs are not necessarily a hindrance as is evident from a study conducted on Mexican immigrants in San Diego.

In this study, Chavez presents the implications of traditional beliefs on contemporary health care, health maintenance and the attitude towards medical professionals in the United States. He further examines the influence of economic situation in determining immigrant attitudes toward health care. Chavez notes that the usual factors that discourage the use of health care services by Mexican immigrants are high cost of health care in relation to low household income; undocumented immigration status; limited medical coverage; general lack of translators; inappropriate operating hours or geographical locations of health care providers (Chavez 1984:

31). Chavez's study counteracts the notion that the continuing belief in folk illnesses and traditional practitioners primarily bars Mexican immigrants from seeking western biomedicine. For that matter, various Latino groups such as Guatemalans and Salvadorians simultaneously seek care from biomedical physicians and herbalists (Chavez et al 2003: 220). Therefore, it is important to consider models of folk illness, the role of socio-economic disparities cannot be ignored in the under utilization of health services by immigrants.

Similarly, Nachman's study puts forth the health conditions of Haitian detainees in a United States federal detention camp for undocumented immigrants in Miami, Florida. This study highlights the tension generated between immigrants and the host country on multiple levels that include health authorities as well as public policy makers. Additionally, Nachman also brings forth the clash between the Haitian's traditional beliefs pertaining to illness and their western diagnosis. The Haitians were diagnosed as suffering from tuberculosis in its early stage, but rejected their condition because they perceived their symptoms to be indicators of other types of disorders. This is because native Haitian etiology does not acknowledge the dormant stage of a disease, in the absence of a germ theory of disease. The detainees would often accord their symptoms to a severe cold or fatigue from their journey (Nachman 1993: 230). Nachman reports that the distrust of Haitians toward immigration officials and physicians, their bid to escape economic and political oppression in Haiti, the expectations of "compliance on part of the immigration and health authorities, the interpersonal conflicts among Haitians themselves perpetuated a constant state of anxiety, depression and desperation among the detainees. This study demands for a more holistic perspective in evaluating immigrant health and experience as it highlights the relationship between environmental stress and depression, as opposed to attributing it to a mere chemical imbalance.

Likewise, Farmer examines the effects cultural folk models of disease on women and their children. The widespread illness known as *movesan* is known to afflict pregnant women and nursing mothers causing their breast milk to be spoiled. Because of this, the infants are weaned early causing a detrimental impact on infant health. The illness is believed to be caused by emotional distress and usually is considered curable by herbal treatment. (Farmer 1988: 2).

Additionally, Pang's research on elderly Korean immigrants in the United States presents the relationship between aging and cultural perception of depression, in relation to traditional models of illness. According to the study's results, fifteen informants referred to depression as a mood, and two thought of it as illness. The informants considered aging, loss of economic or emotional support or bad weather as causes of depression. The informants related depression to Korean illnesses- *han* and *hwabyung*. Coping patterns included behaviors such as singing hymns, being religious and generous, and visiting family. The study indicates that the informants have some idea of depression as a medical disorder, although they do not consider it a serious illness. They believed in controlling depression by cultivating positive behavioral qualities, such as generosity and happiness. Most of them did not feel the need to see a physician, although some of them had sought biomedical and traditional treatment for folk illnesses.

The aforementioned studies postulate the interconnectivity between immigrant health, cultural mindset of both host and native country and public health policy. However, it is important to understand that this relationship is not relegated to conflict alone. The challenge is to recognize the interaction between immigrants and the biomedicine oriented healthcare system

as a symbiotic relationship where both benefit each other in terms of useful information, but also inform each other when deemed necessary. For example, Chavez summarizes the protective nature of certain behaviors and beliefs in his research on Mexican immigrants. He states that many Mexican and Asian immigrant women give birth to relatively healthy children with low rates of low birth weight, in spite of being poor and not receiving adequate prenatal care in comparison to their U.S counterparts. Chavez posits that this is in part due to the lower incidence of smoking and alcohol consumption among these women (Chavez et. al 2003: 206).

### *The Immigrant Diaries*

In this section, I analyze immigrant narratives regarding their experiences in the United States and India. These viewpoints also highlight immigrant perception concerning patient treatment and general attitudes about health and disease. As I have mentioned earlier, the senior Indian immigrants are divided broadly into two transnational groups. The first group consists of immigrants who are residing in the United States permanently whereas the second set of immigrants usually resides with their families on a periodic basis in the United States. Participants from both transnational groups access healthcare amenities in the United States as well as in India. The participants presented conflicting responses with regard to their experiences in seeking healthcare in India and the United States. For instance, one of the participants “Bharti” expressed her apprehensions about receiving treatment in India. According to her, the healthcare system in the United States is more comprehensive and detail oriented when it comes to paying attention to patient history:

K: “Do you regularly see an allopathic physician (or biomedical doctor)? Can you compare your experiences with physicians in the United States and in India?”

Bharti: “Yes. The system over here evaluates the patient properly. They take proper history. Here, there are less patients so they give more time. In India, they handle roughly. There are more patients so they have less time. India has nearly 100 patients on average.”

On the other hand, one of the other participants Raj appeared to be more confident about the healing abilities of the healthcare system in India. According to him, a patient is treated on the psychological as well as the physiological level:

There is a major difference in how Indian doctors treat the disease. They consider you to be human and consider humanity. Here it is business. They just cover for themselves. Indian physicians are right on the track. The treatment is lab based, psychologically based and mental based. There is both physical and mental treatment. Indian system cures completely whereas here one needs repeated visits. Over here, the patient becomes part of the research. You run according to the machines.

Thus, Raj finds the clinical environment in the United States to be impersonal while Bharti feels that it is more thorough in its approach to patient care. Furthermore, the participants placed a significant emphasis on the role of individual agency in health, and provided key insights into their perception of disease in general and the ways in which it can affect them. For instance, Raj developed asthma as a child but was diagnosed with type 2 Diabetes in the United States. He answered in the affirmative when I asked him about any chronic health problems that he may be suffering from but stressed his ability to be in charge of his health:

K: “Do you have any chronic health problems?”

Raj: “Yes. Asthma and Type 2 Diabetes that I have controlled through diet and exercise. I am not a sick person. It is the will of a person. It is one’s own mental power to stay well.”

The abovementioned views underline the participant’s view of how the mind affects the body. His statement that “I am not a sick person” implies feelings of empowerment and control.

However, in Raj’s case, his ability to drive and have a strong social circle positively reinforce his beliefs of self-sufficiency and overall well being. Additionally, the participants also

shared certain beliefs regarding particular diseases, the effect on acknowledging the condition and seeking treatment for those diseases. For instance, AIDS and other sexually transmitted diseases were considered the diseases of “foreigners” usually implying Europeans or Americans. Consequently, these attitudes perpetuated denial in most cases where people experienced symptoms similar to any of these conditions.

Raj: “AIDS and STDs were called *firangi* (foreigner) *rog* (disease). The earlier perception was that these diseases happen to foreigners.”

These opinions put forth contrasting notions pertaining to the kind of treatments received in India and the United States. However, these perceptions also point towards how these individuals relate to their healthcare practitioners and staff and whether that rapport matters to them. These expectations seem to be stemming from not just the kind of medicines administered or their effectiveness but how much time is spent with the patients. For instance, the patient and the medical system that they are dealing with may perceive patient history in different ways. For the patient, medical history might entail particular personal events that they feel have impacted their condition while the western medicine system may focus its patient history on general physiology and diseases prevalent in the individual and his/her family. Therefore, this dichotomous relationship regarding the pros and cons of healthcare in the United States and the native country as per participant standpoint is one of the key factors in transnational networking with regard to immigrant health management.

#### *Biomedicine: Hegemony and Public Health*

The discussion on participants’ use of alternative medicine would be incomplete without examining the historical forces that affected alternative medicine in India and participant attitudes on alternative medicine and Western biomedicine. One of the key inquiries that I had

before embarking upon this research was to what extent do constructions of identity and heritage influence participants' use of alternative medicine, particularly Ayurveda. Therefore, it is necessary to examine the trajectory of alternative medicine in India in a historical light.

As I have discussed earlier, the constructions of the body politic infiltrate beliefs about health and illness in Western and non-Western medical systems. As Baer notes, sixteenth-century Europe witnessed the emergence of European capitalism. This new economic system undermined the value of social, economic and political causes in producing disease (Baer et al 2003: 329). The new economic system was merely a modernized version of the feudal system where the worker is separated from his labor and its' awards in a capitalist society (Marx 2010: 39). Thus, the primary operating principle of capitalist ideology was centered around production and profit that did not acknowledge the interdependent relationship between an individual and his/her environment.

Also, disease was a primary impediment in colonial subjugation of Africa, Asia and the Americas. Therefore, the establishment of medical facilities and staff was necessary in those colonies (Baer 2003: 330). In other words, Western biomedicine trajectory intersected with the missionary objective of labeling traditional knowledge as irrational and vague. Vaughan (1991) underlines the role that biomedicine played in shaping African sensibilities about disease and the African body. In fact, Christian missionaries were opposed to indigenous African medicine labeling traditional practitioners as witch doctors. For that matter, colonial governments discourage indigenous medical systems, since they feared that any kind of communal organization can give way to rebellions (Baer et al 2003: 332).

Vaughan asserts (1991: 5) that biomedicine relies on the objectification of the body alienating the person from the "body." Because of its exclusive focus on hosts and pathogens,

biomedicine only looks at the “natural” origin of disease instead of evaluating its roots in social organization, poverty and repression (Vaughan 1991: 5). Hence, any suggestion of a holistic medicine system did not fit neatly into the epidemiological explanations of a disease.

Consequently, Ayurveda lost its influence under the British policy of decreeing state sponsorship and support to only Western medicine. It was not until the 20<sup>th</sup> century that Ayurvedic clinics and institutions began to be promoted by Ayurvedic doctors and scholars, although biomedicine had gained a strong foothold in the Indian demographic (Langford 1995: 333).

### *Ayurveda: Medicine and Legacy*

As Leggett notes (2006: 19), the colonial imagination assumes the non-Western subject as temporally behind the West and subordinate while the West is supposed to be superior of the two cultures. Therefore, the pre-colonized collective mindset of a select group begins to seek its lost glorious past by seeking a valid identity in one’s national heritage. Thus, personhood and nationhood intersect each other at the juncture of history, nostalgia and possibly a future that can replicate the pride of the pre-colonial era. One of the eminent examples of this identity reconstruction is Baba Ramdev, India’s well-known authority on Yoga. *The New York Times* published an article on Ramdev outlining his achievements and his recent foray into Indian politics (Polgreen 2010). His popular line of Ayurvedic medicines opened recently in Atlanta. Two of the participants in the study shared that they purchased Ayurvedic medicines from Ramdev’s pharmacy. The participants also stated that they watch his yoga telecast on television and internet. When I asked the participants to provide feedback on the revival of Yoga and Ayurveda in India, the participants had slightly differing opinions:

Raj: “Ayurveda and Yoga did not get revived because of Ramdev. Ayurvedic medicines have always been there. I have always used Ayurvedic medicines 90 per cent of the time. I have seen my father treat many diseases with Ayurveda”

Rahul: “Ayurveda and Yoga have been there but Ramdev has brought it into the limelight by organizing Yoga camps. I have faith in Ayurvedic medicine. I know about it.”

Thakur: “Ayurveda and Homeopathy are effective medicine systems. I know it from experience. More people may be believing in it now because of all these movements but they are good medicines.”

Krishna: “It doesn’t matter. It has been a part of India. It is a good medicine system.”

Bharti: “I think the recent movements have played a part but the popularity is not going to matter if the medicines are ineffective.”

Rahul and Bharti further commented that they acknowledge Ramdev’s contribution to spreading awareness regarding Ayurveda and Yoga but do not endorse his entry into politics since that would imply “politicizing” the two. The participants illustrated an overall consensus about the efficacy of Ayurveda. From the interviews, the participants seem to consider Ayurveda as part of Indian history and culture. However, their own experiences regarding its’ efficacy and their socialization into the medicine were more influential in their usage of Ayurveda.

Interestingly, both Ayurveda and Homeopathy have been present on the Indian medical scene for a while now. Also, Homeopathy suffered a setback with the gradual domination of biomedicine (Baer et al 2003: 330). However, Homeopathy does not claim so much relevance in the discourse on identity as much as Ayurveda. This is because Homeopathy did not garner national pride like Ayurveda because it has always been essentially viewed as a foreign import since it was founded by a German physician (Whiteford 1999: 71). Hence, Homeopathy is just medicine but Ayurveda is symbolic of the Indian intellect and identity.

Sen states (2005: 139) that the creation of significant intellectual movements in many postcolonial societies is a form of resistance to traditions and material symbols that are seen as Western. Hence, I would like to posit that the revival of Ayurveda and Yoga has been in part a

postcolonial project as part of reclaiming national heritage from imperial regimes. At the same time, it is also a profitable commercial venture of late considering its marketing appeal to natives and Westerners alike. Thus, it is pertinent for treatment seekers to look for practitioners who do not belong to either brigade.

## CHAPTER 5

### GLOBALIZATION AND THE GOOD FAMILY

The relaxation in immigration policies and the recent upsurge in the Indian economy during the last decade witnessed growth in job opportunities for Indians in general. These changes have further affected the already disintegrating conventional family system in India accelerating the rate at which Indians begin to seek career opportunities abroad. One such change has been in the perception regarding the traditional living arrangements that have ideally favored living with the son instead of the daughter. The belief that sons are meant to be the primary providers and that daughters belong to another family post marriage drives this preference for residing with the son. Similarly, a daughter-in-law is expected to be the caregiver for her husband's family.

However, these norms are undergoing a transition in urban sectors owing to immigration of younger professionals to foreign lands. The immediate family members still hold the primary responsibility of being caregivers even though a person may have the support of extended kith and kin. The migration of younger professionals to the host country consequently leads to the transnational status for senior parents irrespective of whether that implies living with a son or a daughter. For instance, Rahul and his wife stay with their daughter when they visit the United States. They also utilize this time to evaluate their health and obtain their medicines since both have Medicare and Medicaid. Similarly, Raj and his wife receive financial assistance from both their son and daughter though the ways in which they receive that help differs. Their son contributes by wiring a certain amount every month while their daughter has occasionally bought them airfare, medicines or household goods such as furniture:

Raj: “We never differentiated between a son and daughter. The children are doing so much for us. We are lucky.”

Rahul: “We have only one child. Where are we supposed to go? Anyway, it’s the law now that even the parents can stay even with the daughter if there is no other offspring.”

Here, Rahul refers to the “Senior Citizen’s Bill” passed in 2006 by the Indian government which grants elderly parents the right to demand financial assistance and welfare from their children (Lamb 2009: 437). Rahul’s statement is particularly noteworthy because he does not give weight to the conventional taboo of not depending upon a daughter for support. Yet, he supported his statement by citing the legislation because he seems to be aware of the possibility that his peers might judge his living arrangement to an extent.

On the other hand, Thakur and his wife lived with their son and daughter-in-law for five years before they begin living on their own. Initially, Thakur stated that it is better to be independent but later expressed his disappointment over his living arrangements in an apartment allocated for senior housing:

Thakur: “I used to live in a five-bedroom apartment with a large garden before I came to the United States. Now, this is a small apartment. It is strange how times turn.”

Thakur’s discontent over his living situation encompasses not only his sense of self worth but also affects his and his wife’s accessibility to healthcare services. Thakur expressed that his ability to socialize or seek alternative medicine had been limited since he did not have a driving license.

Thakur: “I don’t visit a whole lot of Indian grocery stores because I don’t drive here. I used to drive earlier but not here. We stayed for five years with my son and he used to take us

wherever we needed to go. Now we depend on the transport that the apartment office provides. It takes seniors once or twice a week wherever they need to go.”

All participants admitted to having a broad social network. However, it is clear from Raj and Thakur’s examples that one’s own access to mobility and not just a strong social network influence an individual’s social participation. Also, economic support plays a major role in gaining access to healthcare resources, be it alternative or biomedicine. Both Raj and Thakur do not live with their sons even though both had the conventional expectations of doing so. However, Raj’s ability to drive and extended financial aid from his son and daughter grant him the freedom and the mobility to strengthen his social ties as opposed to Thakur’s capability to do so. According to Sokolovsky, healthy aging is automatically linked to social participation. It is important for aging adults to feel productive towards their family and community (Sokolovsky 2009: Introduction).

#### *The World That Was*

Thakur’s statement about his comfortable living arrangements before his immigration to the United States reflects his nostalgia for a time when he viewed himself as accomplished and autonomous given his professional status of a successful and well-published academic. Therefore, the sense of self and identity is intricately tied to a person’s individual as well as the collective cultural self. Nevertheless, what Thakur reminisces about is a world that is undergoing change. Residences for elders in India are a new phenomenon in the urban sector. However, the mainstream Indian culture exists in an interesting duality in terms of selfhood, even though Western studies have often focused on the split between individual selves and social selves in relation to constructs of personhood.

Traditionally, Indians associate two objectives with aging: spiritual awareness and freedom from material possessions and kinship ties (Lamb 2009: 420). It is obvious that these two objectives exist in contradiction since the notion of detachment and attachment are part of the aging context. According to the traditional texts on Indian way of life, a person is meant to experience life in four stages. The first stage is *gurukul* or leading the life of a student. The second stage is *grihastha* or married life. The third stage is *vanaprastha* which involves meditation or going for pilgrimages. The fourth stage is *sanyasa* or complete renouncement of all familial and worldly bonds. This stage is meant to prepare the individual in preparation of death and attainment of *moksha* or release from reincarnation (Lamb 2009: 420). Thus, these stages represent an individual's embeddedness in the society and kinship ties. At the same time, these stages also suggest the obligation of distancing oneself from all social ties and material possessions.

The participants employed these traditional life stages as a reference for their own living arrangements. For example, Thakur remarked that usually one is unable to abide by the last stage of renunciation of all emotional and material obligations in spite of the fact that this ideology is an intrinsic component of Indian culture and Indian aging:

Thakur: "We just say that we need to leave everything but no one really follows it. We get so attached to our families. It's the Americans who actually go ahead and live the way that the Hindu texts teach by living independently."

Thakur's perception that separate living arrangements among White and African American seniors is a normative and voluntary choice can further the sense of loneliness and isolation because he sees himself as failing to achieve that detachment that ideally he is supposed to as part of his traditional beliefs. However, Lamb writes that not all Indian social theorists

agree with the notion of the living arrangements in a “traditional” family and consider the self-sufficiency of the elderly a positive trend as it allows them to spend more time with their peers instead of undergo parenting a second time by raising grandchildren (Lamb 2009: 434).

Moreover, these findings reinforce the necessity to take into account the differences and similarities in growing older among different immigrant groups (Bhattacharya and Shibusawa 2009: 446).

### *New Beginnings*

At the same time, the participants also shared certain positive aspects of their living arrangements and family dynamics. For instance, one of the participants, Rahul, is writing a book at present, while visiting his family in the United States. As per Rahul, he cherishes his passion for writing and gardening:

Rahul: “I have always wanted to do this but I could not find the time when I was working. Age does not matter as long as one has interest in something.”

Raj and his wife are part of an intercultural theater group consisting of South Asians with whom they participate in plays and musical performances. Raj has also been able to expand his social network by meeting new people through this channel. Raj also expressed similar sentiments:

Raj: In India, elderly people are mostly supposed to lead their lives quietly. Here, one gets to engage in so many activities. No one is going to judge you.”

Thakur: “I want to publish additional research regarding my academic interests.”

Hence, the participants do not feel confined by the stereotypical representations of age that prevail in India. They get to redefine specific areas of their social and physical existence in their new order of living. As a result, they are able to find a personal and cultural expression in

the new living order negotiating their transnational identities. As Sokolovsky posits, (2009: 380) there is an active creation of alternative social spaces by the elderly that are transforming the former negative perceptions of aging. The participants' interest in nurturing social ties and their engagement in artistic endeavors is a witness to this phenomenon. In addition, these social activities are instrumental in forging transnational and local ties through meeting peers with shared interests further reinforcing positive associations of aging.

## CHAPTER 7

## WESTERN AND ALTERNATIVE MEDICINE: A SYMBIOTIC APPROACH

*Alternative Medicine in the United States: Policy and Politics*

The growth of alternative medicine in the United States was not merely the result of its presence as a cultural import but was also affected by certain shifts in policies regarding aging. The minority elders were not particularly taken into account for policy formation from the 1930s through the 1970s owing to a population and low age consciousness among those communities (Torres-Gil 1987: 243). This began to change in 1971 when minority advocates were able to lobby successfully for the rights of their elderly, following which Social Security, Food Stamp and Supplemental Security Income were expanded, benefitting the low-income elderly (Torres-Gil 1987: 244). However, these reforms underwent an adverse effect during the 1980s due to budget cuts in funding for federal programs (Torres-Gil 1987: 245). Additionally, the agency of minority elderly in the political sphere is restricted due to citizenship and linguistic barriers (Torres-Gil 1987: 247).

Moreover, the interest in alternative medicine began gaining momentum in the 1970s owing to dissatisfaction with bureaucratic procedures regarding biomedicine (Baer 2008: 404). The holistic health movement brought out a wide range of alternative therapies such as homeopathy, acupuncture, herbalism and psychic healing. These developments led to the establishment of the American Holistic Medical Association and the American Holistic Nurses Association (Baer 2008: 404). Various biomedical schools also began offering courses on alternative therapies. Furthermore, the rising cost of biomedical healthcare or the need to seek alternatives in cases where biomedicine did not provide all the answers led to the creation of the

Office of Alternative Medicine (OAM) in 1992 by the National Institute of Health for the purpose of studying heterodox therapies (Baer 2008: 404).

In addition, alternative therapies have been a regular feature of certain communities living in the United States. In a study investigating the use of traditional health practices by urban American Indian/ Alaskan Native primary care patients, it was found out that 70 percent of the 869 participants employed traditional Native American health practices (Buchwald et. al 2000: 1191). One of the other objectives of the study was to determine the physiological health of the patients and analyze the healthcare catered to them. Native American medicine was used especially among males suffering from alcohol abuse, and to treat trauma, back pain and other musculoskeletal pain (Buchwald et. al 2000: 1192). This study highlights the relevance of cultural health practices among American Indians/Alaskan Natives.

Similarly, alternative therapies are being adopted by healthcare institutions such as the establishment of a new training program introduced by the medical community in a hospital in Merced, California (Brown 2009). The medical facility has designed a Hmong shaman policy for its Hmong patients who are receiving treatment for diabetes and hypertension. The patients receive medical care from doctors, while the shamans come and perform spiritual healing ceremonies. The training program familiarizes the shamans with the principles of Western medicine, and places value on the patients' cultural beliefs when deciding their medical treatment (Brown September 19).

#### *Applications of Alternative Medicine among Senior Indian Immigrants*

The participants in this study have employed two kinds of alternative medicine systems that are prevalent in India- Ayurveda and Homeopathy. The participants have formerly used or are presently employing Ayurveda and Homeopathy either exclusively or in conjunction with

biomedicine for certain health conditions. Some participants were introduced to alternative medicine in early childhood and others became familiar in later life. The views that the participants express provide an insight into their ideologies of health. At the same time, they also indicate that the practice of alternative medicine is not uniform demographically even though the Indian population in general is aware of alternative medicine Ayurveda and Homeopathy.

Speaking of alternative treatments adopted by the participants, Bharti came down with jaundice after she delivered her first child. According to her, the treatment options for jaundice were limited in the 1970s in biomedicine. She came to know about Ayurvedic medicine from a colleague after she found the biomedical treatment to be not very effective:

Bharti: “I took Ayurvedic medicine for 2 months because Allopathic (Western biomedicine) was not that effective. My Jaundice was really serious at third stage. At that time, Liver 52 was the only medicine that was offered for Jaundice. Other than that, they would give IV and glucose. My colleague recommended Ayurvedic treatment. I am taking Ayurvedic medicine for Arthritis right now and that is giving relief. I have also taken Ayurvedic medicine for my heart for chest pains.”

It is evident from Bharti’s case that she was initiated into Ayurvedic treatment later on in her life but continues it until now. Bharti’s case is noteworthy as her father was a physician trained in Western biomedicine, and was not particularly inclined towards Western alternative medicine. As a result, Bharti was not very familiar with Ayurveda since Western biomedicine was dominant in her geographic region much like most of the country. This also emphasizes the impact of British driven policy changes as one of the reasons for the popularity of biomedicine over Ayurveda, which continued in post colonial India. On the other hand, three other participants, Krishna, Raj and Rahul developed an inclination to alternative medicine early in childhood because they came from a family of practitioners of alternative medicine. Among the participants, both Raj and Rahul suffer from asthma and high blood sugar. Similar sentiments were echoed by Rahul and Krishna regarding the efficacy of Ayurvedic medicine.

K: What other forms of healthcare or treatment have you used in the United States or in India?"

Raj: "I take Ayurvedic medicine 90 per cent of the time because Allopathy is Instant treatment. It suppresses the disease symptoms, but does not cure completely. Ayurveda treats from the roots. Ayurveda has dietary modifications too which doctors do not recommend a whole lot here. I mostly take Ayurvedic medicine for digestion related issues. I take Hingashthak churan, which is helpful in indigestion and constipation. I do not have any major health issues other than having to watch my sugar and asthma but I have seen my father and other Ayurvedic doctors treat black cough, malaria, influenza, dengue, chicken pox and even plague. My wife takes Ayurvedic treatment for her chronic cough. My mother's paralysis was also cured with Ayurvedic medicine."

Krishna: "I took Ayurvedic medicine for gastric pain for three months. It was effective."

Rahul: "In the past, I have taken Ayurvedic medicine for psoriasis and for reducing cholesterol. My asthma and arthritis worsens when I am here (United States). I got Ayurvedic meds from India that is why it is manageable. I also do certain pranayams (breathing exercises) for my arthritis and blood sugar. Here, there is no treatment except painkillers for arthritis. I have also taken Homeopathic medicine for piles and claustrophobia."

Rahul was very specific about the improvement in his condition when I requested him to expand on the effect of Ayurvedic medicine. He stated that he does not experience shortness of breath, which occurs due to azma. The participants have a strong belief in the effect of diet on medication and the ailment. This does not imply that the participants believe in avoiding certain foods permanently but that all foods are not compatible with all medicines and can be detrimental in case of particular disease conditions:

Thakur: "My wife was suffering from fainting spells and numbness in her right hand. So, she had to avoid hot spices, curd and oil."

Almost all participants perceived Western biomedicine to be "instant" in its effect, which outlines their expectations of a medicinal drug. Ideally, one would assume that an effective medicine should not only provide a cure but also accomplish this as fast as possible. However,

the participants' idea of relief or cure is separate from this belief. As per participants, the definition of relief is not measured in necessarily shorter intervals of time but rather its' ability to eliminate the disease on a permanent or long-term basis. Becker and Kaufman illustrate how individuals assimilate chronic illness in their lives, the various perceptions regarding a health condition and the influence of biomedical principles and economics on the experience of illness (Becker and Kaufman 2009: 166). The authors note that there are three dimensions of the illness trajectory: first, the physician's diagnosis and perspective, second, the patient's ongoing experience of illness and third, the extent to which the patient's incorporate the medical perspective into their own understanding of the disease (Becker and Kaufman 2009: 166). Also, the unique ways in which patients interpret their illness affects their course of treatment, response to symptoms and the kind of adjustments that they make in everyday life to manage their illness (Becker and Kaufman 2009: 167).

On a similar note, it is clear from the participants' views that they have sought Ayurvedic or Homeopathic treatment for their respective health conditions exclusively or in combination with biomedicine. There is a possibility that the participants may not have had access to advanced healthcare as they all hailed from modest socio-economic backgrounds. However, this also establishes the effectiveness of alternative medicine for these participants in the absence of or limited access to treatment options. The participants' opinions also present an insight into their views about what it means to be in optimum health. The participants consider diet and the psychological state of an individual to be significant factors in determining one's health. Their views on Western biomedicine as a system that offers "instant" solutions seems to be arising from the observation that they are merely handed medicines instead of being counseled on their diet or any stress that they might be experiencing in their life. This posits the idea that it is not

just the physician's expectation and skill set that determines the patient's course of treatment and recovery, built also the patient's expectation of how he/she is counseled for a particular ailment.

*Transnationalism, Trans-sociality and Healing*

Immigrants tend to seek alternate forms of healthcare in the absence of medical insurance, undocumented immigrant status, unemployment, low income or respective cultural models of health and wellness (Chavez et. al 2003: 221). These transnational networks operate on two platforms. They aid in accessing healthcare needs. Immigrants often seek advice on remedies from other community members exchanging information about spiritual healers, traditional practitioners and herbal specialists (Chavez et. al 2003: 219). A study on Brazilian immigrant women examines their use of transnational medications and health practices (Messias 2002: 185). As per the study's results, immigrants' social networks are linked with their health and employment networks in an intricate manner (Messias 2002: 185).

Likewise, transnational networks serve moral, emotional and financial needs as is evident from a study on Indian immigrants in Dallas. In this study, Brettell explores the construction of immigrant identity and hierarchy through social organizations. These social networks are instrumental in generating social and cultural capital, sharing common goals of preserving traditions, expanding business opportunities, constructing community, and promoting immigrant advocacy (Brettell 2005: 853). Thus, intercommunity bonds go a long way in nurturing cultural identity and social and physical well-being for numerous immigrant populations as part of transnational networks. Furthermore, the use of native language and socialization with members of one's own ethnic community was shown to reduce depression in a study on Korean Americans (Bhattacharya & Shibusawa 2009: 456).

I observed that transnational networks operate in multiple ways among Indian immigrants during the course of my research. These ties are not only helpful in making inroads to alternative and biomedical healthcare sources in India as well as the United States, but also nurture moral, emotional and financial needs. As part of healthcare needs, the participants at times consult alternative medicine practitioners in India during their stay in the United States. The participants also deliver and purchase medicines for each other when either of them is travelling to India:

Rahul: “I call my brother who is an Ayurvedic practitioner. I get medicines from India when someone is travelling. There are some Ayurvedic medicines available here but not all of them. Sometimes, I contact my Ayurvedic doctor in India through phone. I get medicines from India when someone is going.

Bharti: “I usually consult my Ayurvedic practitioner before coming to the United States. I can also call her on the phone in India if I need to.”

Apart from obtaining alternative medicine, some participants also access the health facilities in India that they have received post retirement as in the case of Rahul:

Rahul: “My wife retired as a government employee so she still gets all the facilities. I depend on my wife. Every 10 years we can get new dentures. There is also vision care. Admission to the hospital is free. The cost of certain medications is reimbursed that are on the list prescribed by the doctor.”

Therefore, such facilities are helpful in providing a security net in India as well in case transnational parents are not living close to their children, or have limited financial resources. The participants in this study participate in a number of group social activities though their mobility differs on an individual level depending upon their financial state, and whether they drive or not. Among the participants, Raj, Rahul and Bharti gather for periodic potlucks along

with their other common friends. These potlucks occur once or twice a month at each of their residences in which all participants contribute a certain amount of money. The host of the potluck gets to keep that money and this continues in the same fashion for the next person who is supposed to be the next host of the event.

Hence, the potlucks also function as a form of economic assistance for each participant. These potlucks are typically held as a “senior event” attended only by the participants. The men and women would either make their own separate groups or socialize together. At these potlucks, I observed the participants exchange ideas, recipes and advice regarding health issues, diet or traditional remedies. The participants also discussed their family problems and extended empathy to each other. The participants also engage in poetry reciting events and cultural celebrations that take place at local community centers. The participants also take part in a range of activities from watching movies, singing, and playing cards to celebrating birthdays during senior get togethers.

Among the participants, Raj and his wife are members of a small theater group that has Indians and Pakistanis as members. Similarly, members of the potluck also hail from diverse religious backgrounds. Nonetheless, the participants seem to transcend religious and national identities up to a certain point in their social relations:

Rahul: “We exchange ideas and get to discuss problems. They are from different religions but it does not matter either way. A person feels happy in the company of same age group. We are talking very frankly.”

Raj: “There are similarities in language and culture. People still have their own beliefs but they can be friends.”

This dynamic might be also present because the participants do not feel pressured or influenced by the immediate community to discourage a relationship where there is conflict on a regional, communal or national level. Also, the participants tend to feel affinity towards a person in case of shared history or similar cultural origin. Hence, I propose that through shared transnational identity and socio-cultural ties, these networks foster trans-sociality where political and religious differences give way to shared culture.

#### *Structural Impediments and Healthcare Dilemmas*

Additionally, the participants also experience certain impediments in accessing biomedical or alternative healthcare. These concerns relate to factors that spin from historical times to the present; from colonialism to the changes that globalization has brought within the last decade to South Asia, particularly India. The reduced cost of healthcare in India or the availability of alternative medicine has senior immigrants travelling back and forth between the native and the host country. However, this has its implications with regard to receiving optimum healthcare for transnational senior immigrants. First, it is not always financially viable to travel to India due to the high financial cost of travel. Moreover, the long duration of travel may not always be conducive towards the health condition of an elderly person. It is not always possible to make travel arrangements for another family member to take time off from work to accompany seniors who find it difficult to travel by themselves owing to their physical condition or language barriers. In addition, immigrants face the unavailability of all prescribed Ayurvedic medicines and they generally have to depend upon a friend or a relative who happens to be travelling to or back from India:

Rahul: “Some Ayurvedic medicines are available here but they don’t have everything. They are also more expensive here since they come from India.”

Thakur: “Allopathic medicines are expensive without insurance. However, it can be also expensive to visit an Ayurvedic or Homeopathic practitioner here if the health insurance does not cover it.”

Hence, immigrants are apprehensive about receiving alternative treatments in the United States because the cost is higher in the dollar amount in comparison to their native currency or they have reservations about the medicine’s authenticity. Moreover, the procurement of raw uncontaminated botanical extracts has its challenges in manufacturing Ayurvedic medicine since most of the Ayurvedic botanical samples are obtained from the tribal belts of India and have to go through multiple channels of transport and processing (Patwardhan et al 2005: 6). One of the other issues regarding Ayurvedic medicine is metal contamination so government regulations need to be tightened (Patwardhan et al 2005: 3). When I raised the issue of metal contamination with the participants, they asserted the difference between reliable brands versus unreliable brands of Ayurvedic medicine:

Bharti: “Corruption is there but you have to get the medicine from the right place. Then it is okay. I have not experienced any adverse reactions.”

Rahul: “I only go to qualified practitioners that have been formally trained for five years in Ayurvedic Medical Colleges. Some Ayurvedic pharmacies are better known than others. These pharmacies are recommended by practitioners. They are inspected and regulated by the government. It is illegal to practice without training or renewing the license.”

Thakur: “There are less number qualified Ayurvedic practitioners in India so one has to find the right one. Those doctors are more successful that have an expertise in Ayurvedic as well as Allopathic medicine.”

A similar case in point is the use of imported diet pills among Brazilian women. These compounded pills are banned in the United States because of serious side effects but are commonly prescribed in Brazil (Cohen 2007: 229). However, the participants expressed an overall faith in Ayurvedic medicines but also emphasized the need to visit a reliable Ayurvedic practitioner or purchase medicines from a reputed brand. However, the participants' early socialization into Ayurvedic medicine as in Rahul's case also factors into the ability of differentiating between a trustworthy and an undependable medicinal brand since he possesses considerable knowledge about Ayurvedic medicine himself.

#### *Integrative Medicine: Scope, Future and Intervention*

Considering the above-mentioned aspects, it is useful and necessary to inform and design an intervention that would allow patients to minimize their financial costs and maximize their healthcare opportunities. Apart from the availability of Ayurvedic or other alternative practitioners or medicines, there has been a recent trend of physicians in the United States who are trained in Western biomedicine but also offer integrative treatments. In fact, an increasing number of healthcare providers, hospitals and insurance companies are expressing interest in complementary and alternative medicine (Baer 2002: 404).

However, various Indian families that practice alternative medicine in conjunction with Western medicine are either not aware of the availability of those options in the host country, find those options too expensive or those treatments are not covered under their health insurance. Thus, many immigrants are oblivious to the possibility of receiving alternative treatments from healthcare providers that are also trained in Western biomedicine. This phenomenon also prevails in other countries such as Mexico where many physicians are trained in both biomedicine and homeopathy. For that matter, a substantial proportion of Oaxacan population

relies on standard Western medicine. These physicians usually specialize in homeopathic medicine as postgraduate studies (Whiteford 1999: 70).

Therefore, the future of medicinal practice demands for integrative medicine that incorporates alternative and biomedicine. In the wake of developments regarding alternative medicine mentioned earlier, additional steps have been taken in this direction. The National Center for Complementary and Alternative Medicine was established in 1999 (Baer 2002: 404). The advisory board of this council comprises members that have expertise in naturopathy, acupuncture, chiropractic and massage therapy (Baer 2002: 404). As Baer notes, “we need an ecology of health that interprets human health in a broad context” (Baer 202: 405). Hence, a pluralistic, democratic medical system that is cost efficient and delivers the benefits of biomedicine and alternative healing systems would contribute towards a more efficient healthcare system (Baer 2002: 405).

Aside from the changes on the policy level, particular measures can be taken on the community level that are instrumental in bridging the communication gap between immigrants and healthcare providers. Therefore, an ethnographic needs assessment research can be helpful in evaluating and designing intervention strategies. For example, workshops and seminars can be organized between immigrants and healthcare providers who practice integrative medicine. This can serve as a platform for both sides to educate each other about needs and options regarding treatments. This would also aid in easing the anxiety of immigrants regarding approaching healthcare providers. Also, most physician websites provide a brief overview of their services. However, information about physicians who practice integrative medicine can be displayed in Indian grocery stores and alternative health stores.

Additionally, Indian immigrants regularly participate in cultural events such as musical programs and plays. Some of them also engage in local radio stations. Hence, media coverage can be influential in disseminating awareness because of its capability to garner a broader audience. Ortner emphasizes the value of agency and transformation when she says that people are social actors who reproduce or transform cultural dynamics through their everyday practices (Ortner 2010: 129). Thus, resources for change emerge when they are created, not anticipated. The cultural dynamics that that give birth to politics and inequities are also the fertile bed for social metamorphosis.

## CHAPTER 8

### CONCLUSION

#### *Summary*

There has been an increased influx of Indian immigrants in the United States post relaxation in immigration policies. In the past few decades, Indian immigrants have formed a sizeable minority in the United States. Among Indian immigrants, there has been a considerable rise in the population of senior immigrants owing to family and employment based visas. Similar to other social groups, Indian immigrants import a unique blend of cultural attitudes that shape their experiences in the host country. Cultural beliefs and socioeconomic disparities play a significant role in determining access to healthcare services by immigrants. In addition, immigrants maintain transnational ties that are useful in accessing resources regarding health and employment. Moreover, social relations can transcend ethnic and transnational boundaries on the basis of shared culture and language as was evident during potlucks and other social gatherings during participant observation.

With regard to how culture affects health perceptions, medical anthropologists have critically engaged the debate on the mind-body split associated with Western biomedicine. Medical anthropologists assert that all cultures have medical systems and that biomedicine is a Western ethno medical system. Biomedicine, emerging from Western science and a concept of mind-body separation, is known to understand illness in terms of observable processes or pathogens that affect the body but often does not consider how economic and socio-cultural factors contribute to illness.

Ayurveda and Homeopathy as humoral systems of medicine have been practiced in India for a long time though their prevalence varies from region to region. Most of the participants

were socialized in alternative medicine early in their life and use it in conjunction with Western biomedicine. The participants engage their transnational networks for the supply of alternative medicine. However, globalization and the reclaiming of national identity by certain groups has commercialized Ayurveda.

### *Contribution*

According to Nina Glick Schiller (2003: 120), the studies that explore the relationship between transnational migration and health are scarce even though there is considerable research available on healthcare access and immigrant health in general. Moreover, as Shibusawa and Bhattacharya (2009: 445) note, fewer studies illustrate the link between globalization and the aging experience of senior Indian immigrants. Therefore, in my experience, the research connecting globalization, immigration, aging and alternative medicine is present but has not as such explored these dynamics collectively, especially in case of Indian immigrants. However, this study draws out the interconnectedness of socio-political history, globalization and the use of alternative medicine among senior Indian immigrants.

In addition, this study incorporates the effect of colonialism on the prevalence of alternative medicine. Although this study began as a platform for examining the role of transnational networks and alternative medicine in shaping senior Indian immigrant health, it was necessary to observe these factors in historical and global context. In my opinion, the inability to do so would imply analyzing the research findings in their limited capacity subject to overlooking the historical and global processes that drive health behaviors and choices in the larger picture. In terms of participant data, it is clear that globalization affects immigration patterns, which in turn influence transnational networks and the access to healthcare resources. Similarly, traditional Indian medicine systems such as Ayurveda suffered a decline under

colonialism and the gradual dominance of Western biomedicine affecting the demographic distribution of alternative medicine based on participant data.

*Recommendations:*

Anthropological studies have illustrated that popular culture often associates aging with illness, dysfunction and lack of productivity. These interpretations of aging and illness have been instrumental in shaping healthcare policies. However, the present discourse on aging reflects agency and empowerment with regard to the aging process. At the same time, it is important to consider cross cultural perceptions of health and the role of structural inequities in accessing healthcare services by immigrants.

In terms of healthcare resources, there are structural obstacles to accessing alternative medicine such as delay in receiving alternative treatment due to high travel costs or the inability to travel alone due to health issues. Hence, measures need to be taken in the direction that maximize healthcare benefits for participants and minimize inconvenience and financial costs. Also, certain Ayurvedic medicines may become contaminated during processing. Most participants acknowledged the possibility of contamination in Ayurvedic medicine yet felt that this could be avoided by obtaining medicines from established practitioners and pharmacies.

Furthermore, there has been a growing interest in alternative medicine since 1970s due to dissatisfaction regarding bureaucratic practices in biomedicine. Certain healthcare providers are offering alternative therapies along with Western biomedicine. The present public health scenario calls for integrative medicine considering cross cultural models of wellness and the applications of alternative medicine. Community intervention can further this cause by bringing healthcare providers and immigrants together through seminars and media sources. The objective

is to create a symbiotic relationship between Western biomedicine and alternative medicine that educates and empowers both sides.

*Future Research:*

Given the small scale of this study, I have not explored the interrelationship among gender, transnationalism and health in detail. However, future research should examine the perceptions of health and illness among senior Indian women. Lamb (2000) posits the contradictions between the aging experiences of Indian elderly women and men. Hence, future research studies should aim to understand in what ways do gender norms shape perceptions of health among senior Indian immigrant women and how do those attitudes differ from their male counterparts. For instance, what are the socio-cultural constructs of “illness” and “wellness” among the women as caregivers? In terms of the correlation between transnational networks and immigrant health, Cohen’s study (2002: 183) expands on the use of compounded diet pills among Brazilian immigrant women in the United States. Similarly, in what ways do senior Indian women access their transnational networks that are unique to their needs and how are these choices affected by their financial status?

Likewise, Sargent (2006) puts forth the influence of immigration on Malian women’s health. She posits the challenges faced by Malian immigrant women in their usage of contraceptive pills in France. Malian women are expected to refrain from contraception as per their native cultural norms putting their reproductive health at risk by being expected to undergo continuous pregnancies (Sargent 2006: 31). In this study, my focus has been primarily on the utilization of alternative medicine among senior transnational immigrants. In exploring this particular phenomenon, I have analyzed other factors such as the influence of globalization on immigration and structural obstacles to obtaining healthcare access that influence aging and

health in the United States. However, the aforementioned studies present a case in point with regard to the healthcare access that Indian immigrant men and women are subject to as per their socio-economic status based on gender norms.

In addition, the senior non- White population is expected to rise by 20 percent in 2050 (Torres-Gil 1987: 242). For that matter, two-thirds of the world's population was reported to be in its 60s in 2207 (Sokolovsky 2009: 1). Hence, the challenges faced by the aging population need to be addressed through anthropological research that takes in to account the complex socio-cultural processes affecting aging and health.

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## APPENDIX

## AYURVEDIC MEDICINES AND THEIR APPLICATIONS AS PER PARTICIPANT DATA

MEDICINES	APPLICATIONS
Hridyaamrit	Reduction of LDL (“bad” cholesterol)
Ashwagandha	Reduction of LDL (“bad cholesterol”)
Hingashthak Churan	Digestion
Lavanbhaskar Churan	Digestion
Jamun Powder	Diabetes
Swasari Kwath	Asthma
Swaran Vasant Malti	Asthma
Chyavanprash	Immunity Booster
Muktapishti	Psoriasis