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Characteristics of Asian American Family Caregivers of Older Adults Compared to Caregivers of Other Racial/Ethnic Groups: Behavioral Risk Factor Surveillance System 2015–2020

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Abstract

Asian Americans (AAs) are the fastest-growing racial/ethnic minority group in the United States. While otherwise highly heterogeneous, AAs overall value filial piety and eldercare. This study compared the health and caregiving experiences of AA caregivers of older adults to AA non-caregivers and caregivers of older adults across racial/ethnic groups. We used 2015–2020 Behavioral Risk Factor Surveillance System data for 315 AA caregivers and 3822 AA non-caregivers, plus 395 American Indian/Alaska Native, 1883 Black, 1292 Hispanic, and 20,321 non-Hispanic White caregivers. Among AAs, 4.3% were caregivers, a lower proportion than in other racial/ethnic groups. Most AA caregivers were female (59%), married (71%), in excellent/very good/good health (76%), and with at least one chronic health condition (66%). Other than relationship to care recipients, caregivers' experiences were similar across racial/ethnic groups: most cared for <20 hours/week and provided household and personal care. Efforts to support AA caregivers should be attentive to cultural practices.

Keywords

caregiving; ethnicity; foreign-born; health; race

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Introduction

Asian Americans (AA) are the fastest-growing racial/ethnic group in the United States (U.S.) comprising about 7.2% of the U.S. population (Jones et al., 2021). The proportions of AA foreign-born immigrants are higher than other racial/ethnic groups (Budiman & Ruiz, 2021), with approximately 57% of AAs being foreign-born immigrants—this varies by Asian ethnicity from 27% of Japanese to 85% of Bhutanese Americans. The AA population has grown 88% between 2000 and 2019 (from 11.9 million to 22.4 million) (Budiman & Ruiz, 2021). Despite these rapidly rising numbers of middle-aged and older AAs, their health and healthcare needs remain understudied (AARP, 2014).

AAs are a highly diverse and heterogeneous group of people from over 50 countries and speak 100 different languages (Johns Hopkins Medicine, 2020). At the same time, many AAs share common cultural backgrounds and practices such as collectivistic values, religious beliefs, and family and intergenerational practices, that emphasize respect for older adults (Kramer et al., 2002). Caring for aging family members is embedded into many Asian cultures by children observing or assisting their parents caring for their grandparents or grandparents-in-law while growing up (AARP, 2014). Multigeneration households are common in Asian countries which facilitates and promotes elder caregiving, and this pattern also is similar in AA communities in the U.S. (AARP, 2014; Miyawaki, 2015). Thus, AAs tend to provide intergenerational elder caregiving—caring for at least one generation older family member (Lien & Huang, 2017) due to the Asian cultural concept of filial piety, feeling of obligation, as well as societal expectations (Do et al., 2015). The consequences of these traditional practices have caused mixed results in terms of caregiver burden and caregiver's mental health (Pinquart & Sorensen, 2005). Therefore, it is unknown if they can continue elder caregiving the way they used to do in their home countries. Thus, it is important to explore the caregiving situation in AA communities in the U.S. so that we can better provide appropriate assistance and support to family caregivers, as well as their older care recipients. We examined the prevalence and characteristics of elder caregiving in community-dwelling AA adults (≥25 years) of different ethnic origins and compared them to other racial/ethnic groups of caregivers. Caregiving can create various stressors and bolster relationships, which may impact the caregiver's physical and mental health (Schulz & Sherwood, 2008). Therefore, we also examined the health of AA caregivers compared to AA non-caregivers.

Methods

Data

Data are from the optional Caregiver Module of the Behavioral Risk Factor Surveillance System (BRFSS) administered to a state-representative sample of community-dwelling adults aged 18 years and older in 44 states, the District of Columbia, and Puerto Rico in 2015, 2016, 2017, 2018, 2019, or 2020 (unweighted N = 265,742) in English or Spanish. If a state administered the module for more than one year, only the most recent year of data was used in the analyses. The BRFSS identifies caregivers by asking if respondents have provided regular care or assistance to a friend or family member with a long-term illness or disability during the past 30 days. Caregivers are then asked several questions about the care they provide. BRFSS does not ask for the care recipient's age, so to identify caregivers of older adults we used the caregiver's age and the relationship to the care recipient to estimate whether the care recipient was likely to be age 65 and older. We assumed that each generation is about 20 years apart and considered the following respondents to be caregivers of older adults: (1) aged ≥25 caring for a grandparent, (2) aged ≥45 caring for a parent/parent-in-law, or (3) aged ≥65 caring for a spouse/partner, sibling, or other relative. Respondents were not considered as caring for an older adult if they reported caring for a child, grandchild, or non-relative/family friend, regardless of their age. Caregivers who were not caring for an older adult were excluded from all analyses. When we refer to caregivers hereafter, we mean caregivers for older adults specifically. Non-caregivers had to be at least age 25 to be included consistent with the minimum age for caregivers. All information was self-reported by respondents. The University of Utah considers analyses of publicly available BRFSS data to be non-human subjects research under the federal Common Rule, 45 CFR Part 46.

Measures

We used the computed preferred race/ethnicity variable in BRFSS to classify respondents as non-Hispanic AAs, non-Hispanic American Indian/Alaska Native (AIAN), non-Hispanic Black, Hispanic, and non-Hispanic White caregivers. We excluded the Native Hawai'ian/ Pacific Islander group, as well as multiple race and other race groups due to the small sample size and potential heterogeneity within them. BRFSS includes 6 specific Asian ethnic subgroups: Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese plus an "other Asian" category, and those are combined into one Asian category in the public dataset.

We considered the following aspects of health: self-reported general health status, mental health measured as frequent mental distress, and the presence of chronic health conditions. Respondents reported their general health status as excellent, very good, good, fair, or poor; we created a variable to indicate excellent/very good/good health versus fair/poor health. We defined frequent mental distress as experiencing ≥14 days of poor mental health in the past 30 days. Respondents reported whether they had been diagnosed with each of the following six chronic health conditions: cardiovascular disease, current asthma, non-skin cancer, chronic obstructive pulmonary disease (COPD), arthritis, or diabetes. We created a variable to indicate having at least one chronic health condition among respondents who responded to at least four of the six chronic condition questions.

We reported respondents' sex and collapsed responses to other demographic and health questions based on the frequency distribution to allow as much reporting certainty as possible: age (<45 years vs. ≥45 years), marital status (married/partnered vs. not married/ single), whether or not they have children <18 years old in the household, educational attainment (<college vs. ≥ some college), employment status (employed/self-employed vs. not employed or retired), household income (<$50,000 vs. ≥$50,000/year), and disability status (having a disability was defined as reporting difficulty with mobility, self-care, independent living, vision, or cognitive function). Similarly, we combined response categories within the caregiving experience variables to assure we had adequate numbers within categories to report them: relationship of the care recipient to caregiver (spouse/partner, parent/parent-in-law, grandparent, and sibling or other relative), caregiving duration (<2 years vs. ≥2 years), and average hours per week providing care (<20 hours vs. ≥20 hours). We also reported whether the caregiver helped with household tasks (i.e., cleaning, managing money, preparing meals) and personal care (i.e., feeding, dressing, bathing, managing medications). Finally, among non-caregivers, we calculated the proportion who said they expected to provide care to someone in the next 2 years.

Data analysis

Weighted prevalence estimates were calculated using the weights available for the year and the survey version of the Caregiver Module administered in each jurisdiction. Throughout this manuscript, counts are unweighted and percentages are weighted. We indicated potentially unstable estimates, those with a relative standard error >30.0%. Chi-square tests were used to compare the characteristics of AA caregivers and non-caregivers and to compare AA caregivers to caregivers from other racial/ethnic groups, using weighted data. When calculating proportions within racial/ethnic groups or only among caregivers, we used a subpopulation statement. Analyses were conducted using Stata 17.0 (College Station, TX).

Results

Of the 4440 AA respondents aged ≥25 who completed the Caregiver Module, 9.5% (weighted) were caregivers, lower than the 20.7% ($p < 0.001$) of respondents from all other racial/ethnic groups who were caregivers. However, among caregivers, the prevalence of providing care for an older adult was similar by race/ethnicity: 43.8% of AA and 42.9% of non-AA caregivers ($p = 0.88$).

Table 1 presents the demographic and health characteristics of AA caregivers (n = 315) and non-caregivers (n = 3822). Most caregivers were female (59.3%) and aged ≥45 (82.1%). Most were married (71.1%) and did not have children in the household (81.8%). Educational attainment was high, with 86.2% attending at least some college. Caregivers were most commonly retired (44.9%), though more than one-third were employed (38.9%); most (55.5%) reported an annual income of ≥$50,000. About three-quarters (76.0%) reported their general health to be excellent/very good/good but 65.9% had at least one chronic condition, and 19.3% were classified as having frequent mental distress. Compared to AA non-caregivers, caregivers were more often older, with no children in the household, retired, in fair/poor health, experienced frequent mental distress, and had at least one chronic condition. Caregivers were less likely to be employed than non-caregivers.

AA caregivers most frequently assisted a parent/parent-in-law (39.3%) or a spouse/partner (27.5%; Table 2). About half (48.7%) provided care for ≥2 years and 33.4% provided care for, on average, ≥20 hours/week. Most assisted with personal care (63.0%) and household tasks (78.9%). The prevalence of caregiving for an older adult was higher among other racial/ethnic groups than among AAs (4.3%) (range: 6.6% of Hispanic adults to 12.8% of AIAN adults, $p = 0.04$ to $p < 0.001$). Nonetheless, the characteristics of the caregiving experiences were generally similar across all racial/ethnic groups. Most cared for <20 hours/week and provided help with both household and personal care tasks. There were some differences in the relationship between caregiver and care recipient: AA caregivers were less frequently caring for a parent/parent-in-law than Hispanic or non-Hispanic White caregivers and were more commonly caring for a spouse/partner than Black or Hispanic caregivers. Otherwise, there were no statistically significant differences in caregiving patterns or caregiver characteristics between AA caregivers for older adults and caregivers in other racial/ethnic groups. Among non-caregivers, 12.8% of AAs expected to begin providing care in the next 2 years, which was lower than the proportion of AIAN non-caregivers (17.2%, $p = 0.03$) but similar to non-caregivers in other racial/ethnic groups (i.e., 15.0% of Black, $p = 0.11$; 14.7% of Hispanic, $p = 0.17$; and 14.5% of White, $p = 0.17$ non-caregivers).

Discussion

We found that the characteristics of AA caregivers and non-caregivers were fairly similar. However, AA caregivers were older and had a higher prevalence of chronic health conditions than non-caregivers, which suggests that they may need additional support to maintain their own health and continue in the caregiving role. This was not unique to AA caregivers as the high prevalence of experiencing chronic health and mental health conditions among informal caregivers across racial/ethnic groups has been well documented including caregivers of foreign-born, immigrant care recipients (Geng et al., 2018; Moon et al., 2020; Rote et al., 2019; Wang et al., 2014). All caregivers may have chronic conditions that they need to manage in addition to providing care for an older family member with a health condition or disability.

AA adults served as caregivers less frequently than adults in other racial/ethnic groups. Because of the AA cultural background—elder caregiving as a normal cultural expectation—the lower prevalence of caregivers compared to other racial/ethnic groups of caregivers was a surprise. It could be that elder caregiving is something that is expected among AA cultures and therefore, AAs may not identify themselves as caregivers (Miyawaki, 2017; 2020), and thus, caregiving by AAs might be under-reported. The BRFSS caregiver module is structured so that the respondent is asked about activities that are performed, and no respondent is directly asked to explicitly identify themself as a caregiver: “During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability?” Because caring for their loved ones is a given, some AAs may not think that they are assisting some relatives.

As we noted earlier, 57% of AAs are foreign-born and first-generation immigrants who may bring with them their original home culture and expectations and carry out their traditional cultural activities in the host country (AARP, 2014). However, such cultural practices often change with time in the host country and acculturation, especially among the younger generations (Miyawaki, 2015; 2020). Although AA families may try to maintain the traditional living arrangement of multigeneration households in the U.S., due to different lifestyles and living arrangements in the U.S., adult children may not be able to provide hands-on care as often as they wish despite their cultural background and good intentions (Liu et al., 2018). Those caregivers of immigrant care recipients may feel more stressed and burdened because they may have to spend more time with their loved one’s daily activities and medical care due to different healthcare systems and cultural and linguistic barriers (Moon et al., 2020; Rote et al., 2019).

We need to acknowledge some limitations of this study. Although our sample of caregivers is representative of each state, the final AA sample size was small and we were unable to analyze disaggregated data by state or, due to data access, ethnic subgroup. Like other national surveys (Nugraheni & Hastings, 2021), the BRFSS was conducted only in English and Spanish, so those with a different primary language may not have been able to complete the survey. More than half of the AA population is foreign-born (Budiman & Ruiz, 2021) and only 50% of immigrants from East and Southeast Asia are proficient English speakers (Radford, 2019). Foreign-born AAs more often expect to become caregivers for older relatives than their American-born counterparts (74% vs. 65%) (AARP, 2014). If those who do not speak the survey languages (most likely foreign-born AAs) are not included in the count, this may not fully reflect the picture of AA caregivers.

Conclusion

AA caregivers for older adults generally are older and in poorer health than their non-caregiver counterparts. This study was unique because the prevalence and characteristics of AA caregivers were compared to other racial/ethnic groups of caregivers across the nation. In general, the caregiving experience was similar across racial/ethnic groups, though AA caregivers differed from some other groups in the relationship to the person they cared for. Efforts to support and assist caregivers should be attentive to cultural practices and the demographic and health characteristics of those caregivers. Ethnic-specific adult day centers that provide ethnic-specific meal and activity programs may alleviate AA caregivers who try to adjust to new lifestyles in the host country but try to maintain their traditional elder caregiving culture while they work outside the home (Lendon et al., 2021; Moon et al., 2020; Rote et al., 2019). Some geographic areas where many different ethnic groups of immigrants reside (i.e., California, New York, Texas) have been offering culturally relevant social and nutrition services supported by the Older Americans Act of 1965. As the diversity of the older population will continue to increase, the importance of these ethnically and linguistically responsive programs is paramount. Policymakers should consider measures that provide increased availability of and access to these culturally responsive programs to accommodate the increasing needs of not only AA but also other racial/ethnic groups of caregivers so that they can continue providing adequate care for their loved ones.

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Disclaimer

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What this paper adds

- Despite the cultural emphasis on elder caregiving, the prevalence of caregiving for an older adult was lower among Asian Americans than in other racial/ethnic groups.
- In general, Asian American caregivers were older and had a higher prevalence of chronic health conditions than Asian American non-caregivers.
- Caregiving experiences are similar across different racial/ethnic groups of caregivers.

Applications of study findings

- We should assure Asian American caregivers have support in their caregiving roles and in maintaining their health since they are older and with poorer health than Asian American non-caregivers.
- Since there are many foreign-born Asian American caregivers, we should support them in culturally relevant ways.

Table 1.

Demographic and health characteristics of Asian American family caregivers providing care for an older adult family member and Asian American non-caregivers (N = 4137), Behavioral Risk Factor Surveillance System, 2015–2020[a].

Variable	Category	Caregivers of Older Adults (Unweighted n = 315) Weighted %	Non-Caregivers (Unweighted n = 3822) Weighted %	*p*-value[b]
Sex	Female	59.3	50.3	0.35
Age	25—44 years old	17.9	47.8	**0.006**
	45 years and older	82.1	52.2	
Marital status	Married/partnered	71.1	72.3	0.85
	Not married/single[d]	28.9	26.9	
	Missing	0	0.8	—
Children in the household	At least one child (<18 years old)	18.2	39.9	**0.001**
	None	81.8	58.7	
	Missing	0	1.4	—
Education	High school degree or less	13.8	19.3	0.32
	Some college or higher	86.2	80.3	
	Missing	0.1	0.4	—
Employment status	Employed/Self-employed	38.9	66.1	**0.001**
	Retired	44.9	13.1	**<0.001**
	Not employed (unemployed, student, homemaker, or unable to work)	16.2	20.1	0.65
	Missing	0	0.7	—
Household income	<$50,000 per year	36.7	28.6	0.52
	≥$50,000 per year	55.5	57.0	
	Missing	7.8	14.4	—
Disability status	Has a disability[e]	19.5[c]	14.6	0.47[c]
	Does not have a disability	80.4	84.5	
	Missing	0.03	0.9	—
General health status	Excellent, very good or good	76.0	90.8	**0.008**[c]
	Fair or poor	24.0[c]	9.1	
	Missing	0	0.1	—
Frequent mental distress	Yes – 14 days or more of poor mental health in the past 30 days	19.3[c]	5.4	**0.009**[c]

Variable	Category	Caregivers of Older Adults (Unweighted n = 315) Weighted %	Non-Caregivers (Unweighted n = 3822) Weighted %	*p*-value[b]
	No – less than 14 days of poor mental health in the past 30 days	78.2	93.1	
	Missing	2.5	1.5	—
Chronic health conditions	Cardiovascular disease[f]	2.9[c]	2.1[b]	0.68[c]
	Missing	1.6	1.3	—
	Arthritis	38.8	11.6	**<0.001**
	Missing	0.009	0.8	—
	Current asthma	13.6[c]	5.2	0.13[c]
	Missing	0.02	0.7	—
	Cancer (excluding skin cancer)	28.8[c]	3.2	**<0.001** [c]
	Missing	0	0.3	—
	Chronic obstructive pulmonary disease	0.6[c]	2.3[b]	**0.009**[c]
	Missing	0.04	0.7	—
	Diabetes	19.5[c]	9.7	**0.04**[c]
	Missing	0	0.3	—
Any chronic health condition	At least one chronic health condition listed above	65.9	26.1	**<0.001**
	Missing	0	0.1	—

[a] 2015 states: Alabama, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Nebraska, South Carolina, Wisconsin, Wyoming; 2016 states/territories: Arizona,Arkansas, California, Colorado, Connecticut, District of Columbia, Minnesota, Missouri, Montana, Nevada, North Dakota, Puerto Rico, South Dakota; 2017 states: Alaska, Kansas, Michigan, New Mexico, Oklahoma, Rhode Island; 2018 states: New Jersey; 2019 states: Hawai'i, Maine, Maryland, Tennessee, Texas, Virginia; 2020 states: Florida, Georgia, New York, Ohio, Oregon, Pennsylvania, Utah, West Virginia.

[b] a *p*-value based on the chi-square test of weighted proportions, excluding missing responses.

[c] Estimate may be unreliable; relative standard error (RSE) greater than 30.0%. RSE calculated as the weighted standard error divided by the weighted point estimate and multiplied by 100%.

[d] Includes never married, divorced, widowed, or separated.

[e] Having a disability was defined as reporting difficulty with at least one of the following: mobility, self-care, independent living, vision, or cognitive function. Difficulty hearing was not included because it did not appear on the BRFSS until 2016 and so was not available for all states/territories.

[f] Includes heart attack/myocardial infarction, angina/coronary heart disease, or stroke.

Table 2.

Caregiving prevalence and experiences of caregivers for older adult family members by racial/ethnic group, Behavioral Risk Factor Surveillance System, 2015–2020.[a]

Variable	Category	Asian American (Unweighted n = 315 out of 4137) Weighted %	American Indian/Alaska Native (Unweighted n = 395 out of 3465) Weighted %	*p*-value[b]	Black (Unweighted n = 1883 out of 18,132) Weighted %	*p*-value[b]	Hispanic (Unweighted n = 1292 out of 17,337) Weighted %	*p*-value[b]	White (Unweighted n = 20,321 out of 170,367) Weighted %	*p*-value[b]
Caring for older family member[c]	Yes	4.3	12.8	**<0.001**	9.0	**<0.001**	6.6	**0.04**	11.0	**<0.001**
Mean Age[d]	Years (SE)	57.3 (3.5)	60.2 (2.0)	0.48	55.7 (0.7)	0.66	53.5 (1.3)	0.31	60.5 (0.2)	0.37
Sex	Female	59.3	64.4	0.64	60.7	0.88	53.3	0.56	59.5	0.98
Disability	Has a disability	19.5[e]	44.4	**0.03**[e]	30.9	0.20[e]	35.9	0.09[e]	28.7	0.27[e]
Chronic health condition	Yes, at least 1	65.9	68.0	0.83	49.9	0.07	50.4	0.09	61.4	0.57
	Missing	0	0	–	0	–	0	–	0.02	–
Care recipient’s relationship	Parent or parent-in-law	39.3	44.7	0.62	56.9	0.05	62.9	**0.01**	58.7	**0.02**
	Grandparent	17.8[e]	12.3	0.49[e]	19.0	0.90[e]	20.9	0.75[e]	9.1	0.15[e]
	Spouse/Partner	27.5[e]	31.6	0.77[e]	9.2	**0.01**[e]	10.6	**0.04** [e]	23.2	0.67[e]
	Other relative	15.2[e]	11.3[e]	0.66[e]	14.9	0.97[e]	5.7	0.05[e]	9.0	0.27[e]
Caregiving duration	<2 years	51.0	32.5	0.17	38.4	0.24	37.1	0.25	45.7	0.63
	≥2 years	48.7	61.4		59.5		58.4		52.7	
	Missing	0.3	6.0	–	2.1	–	4.4	–	1.5	–
Caregiving hours (on average)	<20 hours/week	62.3	55.9	0.66[e]	64.3	0.69[e]	59.4	0.92[e]	65.5	0.62[e]
	≥20 hours/week	33.4[e]	38.5		28.2		33.5		27.7	
	Missing	4.3	5.6	–	7.5	–	7.1	–	6.8	–
Types of caregiving tasks	Personal care	63.0	60.9	0.98	57.1	0.61	67.7	0.62	49.9	0.16
	Missing	0.5	3.2	–	2.2	–	0.3	–	1.0	–
	Household tasks	78.9	79.8	0.70	78.0	0.99	83.1	0.48	78.9	0.93
	Missing	0.6	3.3	–	1.9	–	0.6	–	1.2	–

– Not tested. *p*-values are based on estimates excluding missing responses.

[a] 2015 states: Alabama, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Nebraska, South Carolina, Wisconsin, Wyoming; 2016 states/territories: Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Minnesota, Missouri, Montana, Nevada, North Dakota, Puerto Rico, South Dakota; 2017 states: Alaska, Kansas, Michigan, New Mexico, Oklahoma, Rhode Island; 2018 states: New Jersey; 2019 states: Hawai'i, Maine, Maryland, Tennessee, Texas, Virginia; 2020 states: Florida, Georgia, New York, Ohio, Oregon, Pennsylvania, Utah, West Virginia.

[b] P-value based on the chi-square test of weighted proportions comparing Asian American caregivers to the racial/ethnic group to the left of this column. For age, the *p*-value is based on an adjusted Wald test of weighted means.

[c] Caregivers for others were excluded from these analyses.

[d] In BRFSS, anyone aged 80 years or older appears in the dataset as age 80 (to maintain confidentiality). Thus, these means are slightly lower than the true mean age of respondents.

[e] Estimate may be unreliable; relative standard error (RSE) greater than 30.0%. RSE calculated as the weighted standard error divided by the weighted point estimate and multiplied by 100%.