Immigrant Vulnerability: Does Capitalism in the United States Matter?

Jenny Hsin-Chun Tsai

Objectives

At the end of this chapter, the reader will be able to

1. Identify key factors that contribute to vulnerability in immigrants.
2. Describe a plan for a qualitative study on Chinese immigrants.
3. Describe how United States society can shape the lives of Chinese immigrants.

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International migration (or immigration) is an ancient phenomenon. With globalization, this old phenomenon is happening faster and becoming more diversified than ever before. In 1997 in the United States alone, 25.8 million persons—9.7% of the total U.S. population—were immigrants (Schmidley & Gibson, 1999). In 2000, the number of immigrants increased to 28.4 million, representing 10.4% of the nation's total population (Lollock, 2001). The most recent American Community Survey estimates (U.S. Census Bureau American FactFinder, 2008) suggest that there are 37.9 million immigrants, accounting for 12.5% of the total U.S. population, and showing a steady increase in all areas of in the United States. Schmidley and Gibson's (1999) projection indicates that from 1995 to 2050, 40% of the total immigrant population will be Hispanic, 30% will be from Asia and the Pacific Islands, 20% will be non-Hispanic whites, and 10% will be African American. As a result, demand for culturally competent care is knocking on the doors of clinicians, educators, researchers, and healthcare administrators harder than ever before.

Scientists believe that as a result of the extensive upheavals involved in immigration, the health of immigrants is threatened and their risk for poor health is increased after resettlement. In other words, changes experienced during transition add to the vulnerability of immigrants

(Meleis, 1996). With regard to mental health, Ödegaard's (1932) investigation in the United States regarding mental illness in adult immigrants; Rutter et al.'s (1974) survey of children in the United Kingdom; Munroe-Blum, Boyle, Offord, and Kates' (1989) study of children in Canada; Baider and colleagues' (1996) work with Russian immigrants in Israel; Barnes' (2001) screening of recent refugees in the United States; Griffin and Soskolne's (2003) cross-sectional study of Thai migrant agricultural workers' psychosocial distress in Israel; Sundaram, Oin, and Zøllner's (2006) investigation of suicide risks among foreign-born individuals in Denmark; Anbesse and colleagues' (2009) qualitative study of mental health issues of Ethiopian female domestic migrants to Middle Eastern countries; and many other works show various kinds and degrees of adverse mental health consequences for immigrants and refugees.

Studies from other scholars further show factors that are associated with the health status and vulnerability of immigrants. For example, Anderson's study (1985) with Indo-Canadian and Greek women in Canada found that the women's help-seeking experiences were affected by their own perceptions of health, inability on the part of health professionals to grasp the circumstances of their lives, and their experiences of discrimination. Studies with Polish immigrants (Aroian, 1990), Iranian immigrants (Lipson, 1992), and Korean immigrants (Nah, 1993) in the United States showed that language and occupational accommodation were two key factors for successful resettlement. The existence of ethnocultural communities in the area where immigrants move was also found to be important for immigrants' psychosocial adaptation and health (Baker, Arseneault, & Gallant, 1994; Tsai, 2006). Weitzman and Berry's work with poor immigrant women in New York (1992) indicated that being poor and being an immigrant contributed to these women's limited use of U.S. medical care and poor health status. Notably, these women faced even greater barriers to health care than poor and uninsured Americans did.

The transition during immigration and resettlement adds to the vulnerability of immigrants. Nevertheless, this vulnerability is not a static, self-contained entity. Immigrant vulnerability is produced through ongoing interactions with social, economic, political, and cultural structures of the receiving country. Chopoorian (1986) reminded members of the nursing profession that a lack of consciousness about social, political, economic, and cultural factors prevents nurses from arriving at a comprehensive view of human health. Such a lack of consciousness about these issues keeps the profession in a peripheral role in the larger arena of social, economic, and political affairs of the United States. To promote the health of immigrants, health professionals need to "acquire, through their education, a theoretical base that allows them to analyze the socioeconomic and political factors that influence health care delivery" (Anderson, 1991, p. 716) and other aspects of everyday life.

Partial findings of a critical ethnographic study (Tsai, 2001) are presented in this chapter to highlight the effects that the receiving country's economic structure has on the vulnerability of immigrants. These effects are illustrated through events of these individuals' daily lives, their psychosocial reactions, and the adaptive strategies they used during resettlement in the receiving country. The implications of these findings for U.S. health professionals are then discussed.

DESCRIPTION OF THE STUDY

This critical ethnographic study took place in a metropolitan area in the northwest region of the United States between 1998 and 2000. It was designed to explore how immigrant families' lives are shaped by the larger societal context of the receiving country. Data were collected from nine Taiwanese immigrant families recruited through community snowball referrals. Participants were protected through compliance with the university-approved procedures for human subjects.

Sample

A total of 29 participants, representing these 9 families, contributed to the overall data. Of the 29 participants, 16 were parents with a mean age of 45.3 years (standard deviation [SD] = 2.4). Nine had completed college (16 years) in Taiwan, and four had advanced education (3 master's degrees and 1 doctorate) in North America. As for the 13 children, they were between 8 and 21 years of age, with a mean of 16.1 years (SD = 3.7). Their education ranged from second grade to first year of college.

These families arrived in the United States as immigrants between January 1989 and August 1998 through three mechanisms: own employment (n = 3), sponsored by siblings who were naturalized U.S. citizens (n = 4), and returning to the United States (n = 2) (in which case, one of the key family members already had permanent resident status or citizenship in the United States). Most families (n = 8) lived in middle-class areas.

Data Generation

Participants were interviewed one to three times, alone or with other family members. All interviews were semistructured and were conducted primarily in Chinese. English was occasionally used with children who were limited in Chinese proficiency or to convey certain ideas. All of the interviews were conducted at home, with the exception of one participant who chose to meet at a restaurant because his parents and sibling did not participate. The length of visit for each interview ranged from 1.5 to 10 hours. Interviews were recorded on audiotape with the consent of the participants. During the interview visits, observations were undertaken to learn about family dynamics, family structure, family affect, daily family activities, the physical home environment, network contacts, and opinions about extrafamilial environments.

In addition to interviews and observations, each participant completed a demographic and immigration questionnaire at the end of the first interview. The children's version had 21 items and collected each child's demographic information. The adult version had 41 items that gathered each adult participant's individual information and his or her family information. Both Chinese and English versions were available. Assistance was available at the scene to help participants complete the questionnaires.

Data Analysis and Scientific Rigor

Descriptive statistics (frequency, mean, and SD) were used to analyze the questionnaire data.

Narrative analytical technique (Riessman, 1993) guided the analysis of the interview data. In the first step, interviews were transcribed from audiotapes to paper (in Chinese).

Both verbal and nonverbal communications were preserved in the Chinese transcripts. After close examination of the Chinese transcripts, portions of the Chinese language transcripts (i.e., narrative segments) were selected, translated, and preserved in the English-language transcripts for in-depth analysis.

Substantive and methodological codes were written next to the highlighted narrative segments. Other analytical notes were also written next to the related narrative segments. Ongoing comparisons of stories across different family members in the same family and across families were made during the analysis process. Ongoing consultation with senior researchers and colleagues with diverse backgrounds, as well as confirmation with participants, refined the analysis. Fewer and fewer new codes were generated with each newly analyzed interview after half of the interviews were analyzed. Codes gradually merged and became more abstract and analytical. HyperRESEARCH (Version 2.03), a computer-assisted qualitative software, was used to manage the data and emerging codes.

FINDINGS

The in-depth analysis revealed that four aspects of U.S. societal context shaped the everyday lives of immigrants. One of these was economic—that is, the norms, values, and practices defined by U.S. capitalism; the other aspects were immigration policy, Western imperialism, and social class. Marketing culture, insurance, and credit were the three themes of the economic context identified in the data related to U.S. capitalism.

Marketing Culture

Marketing culture refers to "the degree [to] which the norms and practices of business for selling products and making profits for business owners influence immigrants" (Tsai, 2001, p. 168). Similar to what occurs in the rest of the U.S. population, families in this study received multiple phone calls, mailings, or in-person visits for various product sales and donations. Taiwan is a capitalist country, yet its economic structure and culture differ from those found in the United States. In particular, the United States emphasizes individualism and the free market, whereas Taiwan emphasizes collectivism and tighter government control.

Participant families had different cultural knowledge about and conceptions of telecommunications and product sales. Many of them complained about their contacts with sales representatives in the United States. "Ordering magazines is the same [problem]. They knock on your door all the time. Ask you to order, ask you for donation. Many of this type of problem," said one family (Tsai, 2001, pp. 168–169). They were distressed, bothered, and frustrated by these practices and the hassles derived from these practices. As one participant said, "We only called Taiwan for a few minutes. Why it cost so much?! We later knew the reason [because we did not sign up for any long-distance promotion plan]. There is only one phone company in Taiwan. You just need a phone and then you have everything" (mother of two, living in the United States for 18 months at the time of the interview) (Tsai, 2001, p. 168).

Some families were concerned and worried about being cheated or having financial or even legal complications because "there are charges against some wrongdoing all the time in

America. Lawsuits are everywhere" (Tsai, 2001, p. 169). The levels of frustration and worry were found to be higher within the participant families who were less proficient in English or who did not have friends or relatives in the area to which they moved.

Families usually thought of strategic solutions to decrease their stress level and protect themselves after a few bad experiences with sales people. For instance, some families chose to say no to everything and stick with whatever (telephone company, magazine subscription) they had at the time. After learning from friends or relatives with knowledge about the U.S. marketing culture, another strategy was sometimes adopted by the immigrants: speaking with a strange foreign accent or improper grammar in hopes that this behavior would stop salespersons from further explaining their products. Some families adapted to the U.S. marketing culture by adjusting their personal perceptions. They treated the money lost to purchasing products they regretted as the "tuition" they had to spend as part of their immigration journey. "Be careful" was the phrase used by some participants throughout the interviews.

Insurance

Insurance is "the types and amounts of insurance necessary to adequately protect the families" (Tsai, 2001, p. 171). Health and life insurance were exported from the United States to Taiwan decades ago. Thus Taiwanese are familiar with the concepts of health and life insurance. Because of the increasing use of cars in Taiwan, car insurance was adopted in Taiwan in the mid-1990s. After participant families immigrated, they began to realize that many more types of insurance existed in the United States. As one participant said, "Everything needs to be insured." The expense of insurance was much higher than they had expected.

The participant families' greatest concern was the cost of health insurance. Taiwan has a universal healthcare system. Having to purchase one's own health insurance when not employed was an unfamiliar concept to families who were new to the United States. In one family who immigrated as an investment, members did not realize that they needed to purchase individual health insurance until they became involved in the local Taiwanese community. Families felt helpless in the face of the high cost of health insurance; at the same time, they could not go without insurance. Unfortunately, the road to finding a health insurance plan was not straightforward. There are many insurance plans offered by different companies. Before participant families could even make a decision, they had to learn about copayments, deductibles, preferred doctors, prevention, and so forth. For participant families who spoke limited English, choosing an insurance plan was challenging. They had to rely on relatives or friends in the area (more so than did those families who were comfortable with English) to resolve the insurance issues.

To overcome the problems with insurance, the first step was staying as healthy as possible to avoid healthcare expenses while the family was looking for jobs that offered benefits. One family said, "When we just got here, we had no insurance. Could not get sick! We bore with it for half a year. Took some over-the-counter drugs [when we're sick]" (Tsai, 2001, p. 173). Some families flew back to Taiwan for their healthcare needs, usually the nonemergency kind, because as one participant said, "Add a round trip ticket on top of [the treatment cost], I still

have plenty left. It's still cost-effective" (Tsai, 2001, p. 172). A few families would just pay for the insurance regardless of the cost because they knew the importance of having insurance in the United States.

Credit

Credit refers to "the degree of which the value of credit affects immigrant families in the [United States]" (Tsai, 2001, p. 174). In capitalism, credit means money and profits (Weber, 1992). Credit history—a widely used concept in the United States—is employed to assess a prospective customer's potential for profit making for the business owner. A good credit history means a potential for making profits from this prospective customer. However, credit history is not a concept that exists in Taiwan. Thus families living in the United States for the first time were surprised and confused when apartment managers asked about credit history and requested investigation fees. Although families in the study were lucky enough to have the investigation waived, some had friends who could not even rent an apartment because they had no credit history at the time. One family said that a friend had to pay six months' rent in advance in cash to secure a place to live.

The lack of credit history not only presented problems for immigrants' access to housing, but also hampered their ability to get loans and credit cards and, ironically, chances to build up their credit history. In the area of loan and credit card applications, no family was lucky with these services. As one unhappy family described their experience: "American banks were not willing to loan to us because he wants you to use credit as deposit, right? Chinese use properties as deposit for loans. That's the difference" (Tsai, 2001, p. 128). Families eventually turned to Chinese-owned banks for help. Regardless of the fact that the process with Chinese-owned banks was not completely smooth, families at least got the loan or credit card from the bank as a start.

DISCUSSION

Decades of studies of immigrant experiences have informed us of the resettlement experience and its accompanying threats to immigrant health in countries such as Canada, the United Kingdom, and the United States. Analysis of the stories of nine Taiwanese immigrant families reveals that immigrants' everyday life is inseparable from the economic structure of the receiving country. Three capitalist practices—the marketing culture, insurance, and credit—create a living context that increases immigrants' vulnerability in the United States.

The financial burden, potential legal ramifications, and limited access to housing, loans, and health care are not the kinds of experiences that immigrants to the United States anticipate before their immigration. Literature has shown that when people move into a new country they have to adapt, to varying extents, to the language used by the receiving country, the physical environment, the culture, the systems, the loss of social support, and economic survival (Aroian, 1990; Baker et al., 1994; Lipson, 1992; Sam & Berry, 1995; Tsai, 2001). These adaptive processes can last from years to a lifetime. Such unexpected experiences represent additional stressors that place individuals in the United States at risk while they are

attempting to manage the other demands they must face as immigrants. Moreover, as part of the capitalist environment or economic structure, people in the United States are always bombarded with sales promotions for new products, business changes, new insurance coverage, and increases in healthcare costs. Even Americans who were born and raised in the United States struggle to understand the changes and choices available to them and to deal with these economic practices.

Immigrants—and particularly new immigrants—can easily get lost in the massive amount of information thrown at them. Making an informed decision is a much more challenging and stressful process for new immigrants than for native-born Americans and established early-wave immigrants. In other words, immigrants' vulnerability exists along a continuum. The degree of the vulnerability increases when the receiving country's economic structure intersects with immigrants' language challenges, unfamiliarity with the systems, or limited access to local social networks for support. In this study, the participant families (who had been in the United States no more than 10 years) discussed their self-doubt about the decisions they made; they revealed their worries and frustration about the financial and legal consequences of their decisions. Unlike those citizens born in the United States, immigrants can face deportation for numerous legal issues (e.g., not reporting an address change to the immigration authority, speeding tickets, credit problems, or crime). Thus, not only are immigrants concerned about the same financial and legal consequences as the people of the receiving country, but they also need to worry about the legal consequences specifically tied to their immigration status.

Navarro (1993, 2003) argues that the problems of the U.S. healthcare system cannot be understood without including capitalism—the moving force behind the financing and delivery of health services in the United States—in the discussion. Health insurance companies are controlled by corporate owners and have a tremendous power over how services are provided by health care providers. Profit and efficiency are the bases for their decision. Insurance premiums are raised to cover growing medical costs and ensure profits. In response, employers shift the cost of insurance premiums to their employees or provide limited choices of insurance plans or no insurance at all. More people become uninsured and face greater barriers to access health care for treatment and illness prevention (Asplin et al., 2005; Himmelstein, Woolhandler, & Hellander, 2001; Kleinke, 2001; McCollister, Arheart, Lee, Fleming, Davila, & LeBlanc, 2010; Taylor, Larson, & Correa-de-Araujo, 2006). Capitalism in the United States has an intimate relationship with immigrants' everyday experience: This economic framework not only shapes the nation's healthcare system, but also drives the production of goods and marketing, the creation of insurance policies, and access to those things which fill basic needs. To decrease immigrants' vulnerability and promote their health, it is absolutely essential to include capitalism in the discussion.

IMPLICATIONS FOR HEALTH PROFESSIONALS

Health professionals have ample opportunities to work with immigrants: in acute care settings, primary care settings, long-term care facilities, community clinics, workplaces, home settings, and schools. In fact, health professionals are in a valuable position to ensure health equity for immigrants.

This section offers some ways for health professionals to be true health advocates for this often vulnerable population.

As a micro-level approach, during visits health professionals should include questions that can help them better understand the effects of the U.S. capitalist economic structure and practices on the stress levels and well-being of immigrant clients. Because immigrant clients are already using their individual resources (e.g., personal intelligence and knowledge, social networks) to develop sufficient strategies to overcome those stressors, health professionals can (and should) serve as another resource for these clients. If immigrant clients do not have adequate individual resources to develop effective adaptive strategies, health professionals should then initiate the discussion and collaborate with the clients to formulate some potentially practical and successful strategies.

In addition to changing their own practices, health professionals should share their knowledge with their colleagues and policy makers to heighten their awareness of the effects of the receiving country's economic structure on immigrants' vulnerability and health status. With such greater awareness, fewer health professionals and policy makers will use culture or language barrier as a catch-all category to explain all immigrant experiences (McGrath, 1998; Tsai, 2003). Instead, more will have a more comprehensive understanding of immigrants' experiences and healthcare needs. As a result, more health professionals and policy makers will provide relevant interventions for the immigrant population and engage in the reconstruction of social and health policies that are driven by U.S. capitalism—a system that is beyond immigrants' control, yet has tremendous effects on their everyday lives.

CLOSING THOUGHTS

Immigrants are at a higher risk for poor health. Nevertheless, their risk is not solely a result of their language skills, education, levels of assimilation to the receiving country, or knowledge about the systems of the receiving country. The country's own historical, sociocultural, economic, and political structures play significant roles in shaping immigrants' everyday experiences and health status. This chapter has provided some preliminary insights into the effects of the U.S. economic structure on immigrant vulnerability. To provide culturally competent care to the immigrant population, further investigation into each of these structural effects and their interactions with immigrants' vulnerability is crucial. Cross-national comparison is needed as well. Of course, it is also necessary for more health professionals and policy makers to recognize that the health experiences and stresses that immigrants identify are, indeed, products of complex social processes. Immigrants then will not be blamed for their problems while the "causes" of the problems lie in the larger societal context.

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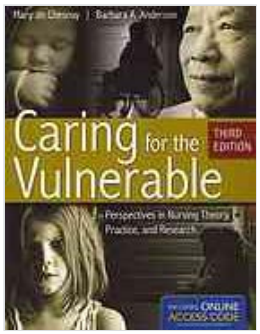

Caring for the vulnerable : perspectives in nursing theory, practice, and research

Author: Mary De Chesnay; Barbara A Anderson

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Summary: Within an expanding field of study in both undergraduate and graduate nursing curricula, this Third Edition explores vulnerability from the perspective of individuals, groups, communities, and populations while addressing how vulnerability affects nurses, nursing, and nursing care. This new edition presents a basic structure for caring for the vulnerable with the ultimate goal of providing culturally competent care.

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Abstract:

Within an expanding field of study in both undergraduate and graduate nursing curricula, this Third Edition explores vulnerability from the perspective of individuals, groups, communities, and populations while addressing how vulnerability affects nurses, nursing, and nursing care. This new edition presents a basic structure for caring for the vulnerable with the ultimate goal of providing culturally competent care. Theoretical and research chapters progress towards others offering meaningful learning experiences for both nursing students and practitioners. Further, since nurses are the crucial link between those who are vulnerable and those with access to solutions, this text provides ideas for how nurses might advocate for the vulnerable on a policy level. Written specifically for nurses by nurses, this Third Edition is a timely and necessary response to the culturally diverse, vulnerable populations for whom nurses must provide appropriate and precise care.

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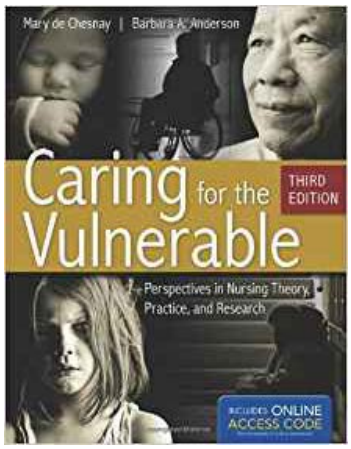

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