Received: 11 May 2022 | Revised: 19 August 2022 | Accepted: 25 August 2022

DOI: 10.1111/jocn.16521

Journal of Clinical Nursing WILEY

EMPIRICAL RESEARCH QUALITATIVE

Navigating asthma—the immigrant child in a tug-of-war: A constructivist grounded theory

Indu Sudarsan MSN RN PhD Candidate, Registered Nurse[1] | Karen Hoare PhD MSc NP, Professor, Adjunct Associate Professor[2,3,4] | Nicolette Sheridan PhD MPH RN, Director[5] | Jennifer Roberts PhD RN, Senior Lecturer[6]

[1]Massey University, Wellington, New Zealand

[2]School of Nursing, Massey University, Auckland, New Zealand

[3]Nurse Practitioner for Children and Young People, Greenstone Family Clinic, Auckland, New Zealand

[4]College of Healthcare Sciences, James Cook University, Townsville, Australia

[5]Massey University, Auckland, New Zealand

[6]School of Nursing, Massey University, Wellington, New Zealand

Correspondence
Indu Sudarsan, Massey University, Wellington, New Zealand.
Email: indunair2@gmail.com

Abstract

Background: Avoidable hospitalisation rates for Indian immigrant children with asthma is high in New Zealand and other Western countries. Understanding how children and their carers manage asthma may lead to a reduction in hospitalisation rates. The topic of asthma and Indian immigrant children's perspectives has not been investigated. Most studies on the topic focus on the experiences of family carers and health professionals. Practice cannot be advanced in the child's best interests unless the child's asthma experiences are explored. The following research addressed this gap by upholding Article 12 of the United Nations Convention on the Rights of the Child, thereby giving Indian immigrant children a voice in describing their asthma experiences.

Design: Constructivist grounded theory.

Methods: Intensive interviews were conducted with ten family carers and nine children (eight to 17 years old). Child-sensitive data collection techniques such as drawing, and photography were used to facilitate interviewing children younger than 14 years. The COREQ guidelines guided the reporting of this study.

Results: The theory, *navigating asthma: the immigrant child in a tug-of-war*, is the resulting grounded theory with the *tug-of-war* being the basic social process. This theory comprises three main categories: being fearful, seeking support and clashing cultures. The data reflected two types of tug-of-war: one between two cultures, the native Indian and the host New Zealand culture and another between family carers' and children's preferences.

Conclusion: Acculturation and sociocultural factors may significantly influence the asthma experiences of Indian immigrants.

Relevance to clinical practice: The theory may assist healthcare practitioners to better comprehend Indian immigrants' asthma experiences within their wider sociocultural context. Our research indicates the need for healthcare practitioners to work in partnership with Indian immigrant families to implement culturally safe asthma management strategies.

KEYWORDS
asthma, belief, child, culture, experience, grounded theory, immigrant, India, practice, respiratory

1 | INTRODUCTION

Asthma is one of the most common chronic respiratory diseases in children globally, adversely affecting the quality of life and placing considerable strain on the healthcare system (O'Connell et al., 2021; World Health Organisation [WHO], 2021). It is one of the top ten causes of disability-adjusted life years (DALYs) in children aged 5–14 years and is the major cause of chronic disease-related school-absenteeism. (Ramdzan et al., 2019; Schlichting et al., 2021; WHO, 2021). Asthma is also a major health issue among Indian immigrant children as evidenced by high avoidable hospitalisation rates in New Zealand (NZ), the USA, the UK and Canada (Lakhanpaul et al., 2019; Mehrotra et al., 2014; Mehta, 2012; Scragg, 2016; Stanojevic et al., 2014; Sudarsan et al., 2022b). The increased morbidity and hospitalisation due to asthma among Indian immigrant children in NZ have been reported since 2006. No further research to date has focused on Indian immigrant children to explore their experience of living with asthma or has explained why this group presents with a high avoidable hospitalisation rate, or what nursing measures are taken or could be done to prevent future hospital visits (Mehta, 2012; Plunket., 2015; Scragg, 2016; Wong & Tsang, 2018; Yong, 2018).

Additionally, the inclusion of Indians under the category of *South Asians (SA)* raises serious concerns (Parackal et al., 2021; Sudarsan et al., 2022b). According to the NZ Ministry of Health coding, the SA group refers to people from India, Pakistan, Afghanistan, Bangladesh, Nepal, Sri Lanka and Fiji. When used in health research, this broad ethnicity classification may not only fail to capture SA's rich cultural diversity, but may also obscure significant differences in disease prevalence, risk factors and health indicators among different subgroups. While the Indian ethnic group itself is diverse in terms of their language, food habits, religion, culture and other aspects, studying this group alone is essential to yielding more reliable findings (Ahmed et al., 2018; Parackal et al., 2021; Wong, 2015). Moreover, as more Indian immigrant children utilise the healthcare system, the number of healthcare professionals (HCP) who are exposed to these children will grow. This forecast calls for proactive approaches to developing health policies for Indian immigrant children in key areas of health concerns such as childhood asthma (Lakhanpaul et al., 2019; Scragg, 2016).

Furthermore, the extant literature on Indian immigrant children's asthma focuses on the experiences of family caregivers and HCP (Lakhanpaul et al., 2019). Indian immigrant children's voices tend to be excluded in research because of various cultural and linguistic barriers associated with researching immigrant children. For example, a major cultural barrier to engaging Indian immigrant families in asthma research is the social stigma attached to childhood asthma in Indian communities. NZ healthcare providers have frequently stressed the need for extra support such as the involvement of cultural mediators, interpreter services and/or capacity building to provide effective healthcare to migrants (Kanengoni et al., 2018; Lakhanpaul et al., 2014). The current study upheld Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) and gave Indian immigrant children a voice in describing their experiences of asthma (Sudarsan et al., 2022c; United Nations International Children's Emergency Fund [UNICEF], 2006).

What does this paper contribute to wider community?

- The theory explains the complex interplay of various influences, such as sociocultural factors and acculturation, in the development of shared values, preferences and priorities among Indian immigrant children with asthma and their family caregivers.
- The study reveals several tensions and ambiguities regarding the inclusion of children's voices in asthma care decision making.
- The theory stresses the importance of providing culturally safe nursing care, which integrates patients' care experiences and cultural beliefs about various illnesses and treatments, allowing care to be defined by those who receive it.

2 | STUDY AIM

The aim of the study was to explore the beliefs, practices and experiences of asthma among Indian immigrant children and their family caregivers using a Constructivist Grounded Theory (CGT) approach.

3 | METHOD

3.1 | Design

The study was guided by the CGT methodology, with *social constructionism* as the underpinning theoretical framework. CGT focuses on the social construction of knowledge, which highlights the importance of multiple perspectives of reality in this extremely complex social world (Berger & Luckmann, 1991; Charmaz, 2014). CGT emphasises that researchers are co-constructors of knowledge in the research process. (Charmaz, 2014). IS (first author) is an Indian immigrant registered nurse (RN), a former paediatric RN, and a mother of

three children. She considered her personal and professional experiences integral to effectively addressing the research aim (Sudarsan et al., 2022a). Being reflexive is important in CGT and IS recorded her thoughts in the form of memos throughout the project (Singh & Estefan, 2018). Using an interview guide (File S1), IS employed semi-structured intensive interviews with children (8–17 years old) and their family carers. Child-sensitive data collection techniques such as drawing, and photography were used to facilitate interviewing children under 14 years of age. The recruitment and data collection of this study are described in detail elsewhere (Sudarsan et al., 2022c) (File S2). The X University Human Ethics Committee granted ethical approval for the study (Reference number: NOR 19/62). Table 1 illustrates the characteristics of the 10 children and nine family carers who participated in the study. The consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) guided the reporting of this study (File S3).

3.2 | Data analysis

Concurrent data collection and analysis took place, accompanied by memoing. Data analysis was conducted manually and involved phases of initial, focused and theoretical coding. In the initial coding phase, IS conducted line-by-line coding of each transcript following each interview. Gerunds (verbs ending in 'ing') were mostly used to code transcripts. The use of gerunds facilitates the study of enacted processes, indicating that theoretical insights can be developed by focusing on actions and processes rather than individuals. Similar codes were grouped into categories, each defined by its own properties and dimensions (Charmaz, 2014). Concurrent data analysis provided leads for IS to follow in subsequent interviews and guided theoretical sampling. IS constantly engaged with the data by continually comparing all the data sources to facilitate progression to subsequent phases of analysis. To process large volumes of data and enhance the initial codes, a focused coding approach was applied. Finally, theoretical coding was employed to conceptualise the relationships between various codes. Data collection was stopped when theoretical saturation was attained by the 19th interview, when no more new codes were constructed. IS utilised NVivo 20 software for data organisation and storage. The grounded theory of navigating asthma—the immigrant child in a tug-of-war comprises three categories, *being fearful*, *seeking support* and *clashing cultures* and is depicted in Figure 1.

4 | RESULTS

4.1 | Explaining the *tug-of-war* metaphor

The tug-of-war occurs in asthma management because of the clash of cultures that participants experience as they transition between enculturation and acculturation. Several challenges arose as they tried to reconcile the Western approach to asthma with the Indian approach. The cultural clash was evident from the first interview, but the metaphor of tug-of-war was the basic social process constructed following identification of three main categories.

The data reflected two types of tug-of-war: one between the Indian and NZ culture, and another between carers and their children. The following conversation between a 12-year-old child participant and her mother demonstrates the tug-of-war that occurred between the family carer and child:

> Yes, I have many [friends]. They have those inhalers, and they carry that. But I don't as my mum does not want me to.
>
> (C10, 12Y/F)

TABLE 1 Participant demographics

Family carer's code	Relationship with the child	Child's code	Child's age (Years) /gender	Child's birth country /years in NZ	Years in NZ (family carer)	Family carer's occupation
P1	Mother	C1	8Y/M	India/3	4	Teacher
P2	Mother	C2	10Y/M	India/7	7	Self-employed (Owns a restaurant)
P3	Mother	C3	16Y/F	NZ/16	17	Self-employed (Owns a restaurant)
P4	Father	C4	8Y/M	NZ/8	14	Quality manager
P5	Mother	C5	9Y/M	India/3	6	RN
P6	Father	C6	9Y/F	India/4	6	Engineer
P7	Mother	C7	15Y/M	India/2	2	Unemployed
P8	Mother	C8	8Y/M	India/1	2	RN
P9	Mother	C9	13Y/F	India/3	6	RN
P9	Mother	C10	12Y/F	India/3	6	RN

Note: P9's two children took part in the study.

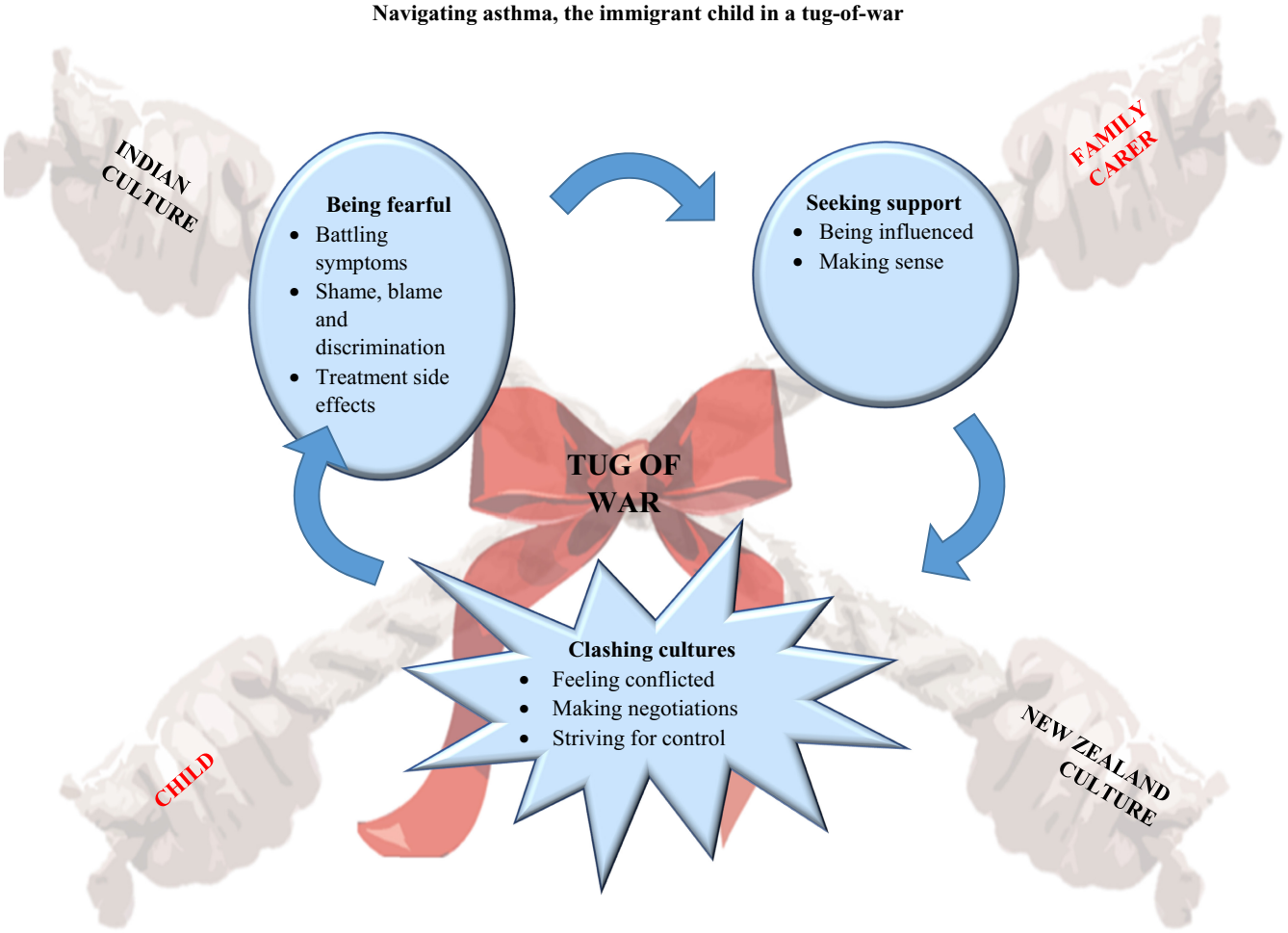

FIGURE 1 Navigating asthma—The immigrant child in a tug-of-war [Colour figure can be viewed at wileyonlinelibrary.com]

> I told her (to C10) why I said that. She wants it to be carried like them. If she carries, she will use it unnecessarily.
>
> (P9/Mother)
>
> No, I won't.
>
> (C10, 12Y/F)

4.2 | Theory summary

The theory of navigating asthma, the immigrant child in a tug-of-war, is presented using storyline. According to Birks and Mills (2020), a 'storyline facilitates the development of a digestible, readable expression of a grounded theory' (p. 252). The following storyline illustrates the three categories of being fearful, seeking support and clashing cultures and their sub-categories (see Figure 1).

Children and their family carers experienced a feeling of ongoing fear (*battling symptoms*, *fear of blame*, *shame and discrimination* and *fear of treatment side effects*) which became the first phase of being fearful. They sought support regularly to overcome their fears, which became the subsequent phase of seeking support with two subcategories of *being influenced* and *making sense*. In addition to their cultural beliefs and personal experiences, the participants were constantly influenced by several people in society; they were bombarded with information from a variety of sources (parents, extended family members, health experts and peers) based on which they attempted to make sense of asthma. This led to the final phase of clashing cultures.

Clashing cultures, the core category, is comprised of three subcategories: *feeling conflicted*, *making negotiations* and *striving for control*. The participants developed a feeling of being conflicted as they were often caught between contradictory interpretations of asthma arising from Indian cultural values on one hand and Western values on the other. Tensions arose as the family carers tried to incorporate their cultural expectations into the child's plan of care, which often differed from the children's choices. While children and their family carers made a range of decisions depending upon the context and the uniqueness of each family, these decisions often ended up in making negotiations centred mostly around family

carers' preferences. The tensions and ambiguities around including children's voices in asthma-care decision-making were apparent throughout the study. Feelings of helplessness and powerlessness were evident as children talked through their issues. A cultural clash was evident throughout their asthma journey, and the child tended to become the *piggy-in-the-middle* as they strived to gain control over the condition.

The progression through the three phases was not linear. The three phases proceeded in a cyclic pattern. Indian immigrant children and their family carers reflected on their asthma experiences. They modified their approach to the condition as they acquired new insights from their personal experiences and support networks, which helped them manage their varying degrees of fear at different times during their asthma battle. The participants went back and forth between these phases in their asthma battle based on changing internal and external influences.

4.2.1 | Category 1: Being fearful

The overarching emotion expressed by the participants as they discussed various elements of asthma was that of fear. There are three sub-categories under the category of being fearful, which include battling symptoms, fear of blame, shame, and discrimination and fear of treatment side-effects.

- **Battling symptoms**

While younger children articulated their fears predominantly about triggers and symptoms, older children and family carers voiced their worries about uncertainty due to the unpredictability of the disease.

> I get stressed about it [asthma flare-ups] if there are some pending assignments. So, I try to take the precautions to prevent flare-ups during that time. I also get nervous around that time. Like… if I will get flare-ups or not.
>
> (C9, 13Y/F)

> Hoping and praying to God that he will be fine. I hope he does not use all this thing [inhaler] in the future. Now he is fine. But I don't know how he will be in his teenage age with inhalers. Hopefully, everything will go away, and he will be fine.
>
> (P5/Mother)

Family carers monitored their children closely and warned them of situations where they might be exposed to triggers. One of the common findings under this sub-category was the fear of the *cold*, considering it as trigger. Triggers listed by family carers included cold foods, weather, showers and other factors that cool the body, including playing in the water. Cold foods not only included physically cold foods but also foods that had a cold base such as milk, bananas or grapes were believed to trigger asthma flare-ups by increasing phlegm production. One of the family carers explains this idea in the following data segment:

> So, the ice cream mainly. Among the fruits, the grapes are the worst thing I feel because it makes the body cool and he suddenly… he gets fever, and it triggers him, and it later ends up in asthma. Whenever he gets sick, I also restrict him, not to shower. Yeah, I feel like it is getting his body again cold and sick…. sick again… so, I used to restrict him. So, I believe everything helped him one or the other way.
>
> (P7/Mother)

Family carers' guidance on the hot-cold theory was echoed in children's conversations.

> Don't eat ice creams. Don't play outside…only on sunny days. Yeah, and they say to drink hot water.
>
> (C8, 8Y/M)

Fear of sports or physical activities was another common theme that was identified during the interviews. Family carers who held this belief restricted children from it.

> We started swimming lessons for the elder one, but we didn't start for him [her son with asthma] because we were scared like how he will he cope.
>
> (P1/Mother)

Children who had a history of severe asthma attacks during sports or other physical activities expressed their fear of engaging in the activities, which further reinforced their carer's advice of considering it as a trigger.

> I know my restrictions. Sometimes, I can't play with my friends. My friends used to play rugby and all other kind of things. I like cricket a lot. But I can't play because of the problem [asthma]. Because I know I might get an attack if I am over doing. Yes. I had it may be once or twice actually. I got scared of it and have never done it after that because once I was playing cricket, I had it and it was really bad.
>
> (C7, 15Y/M)

- **Fear of blame, shame and discrimination**

Family carers and older children were conscious of the stigma existing in the Indian community and their approach towards asthma was guided to an extent by their level of perceived stigma.

> If someone knows the stories out of our house, it might affect her [child's] future life.
>
> (P9/Mother)

Although young children did not explicitly address stigma, their experiences indicated the indirect influence of family caregiver stigma. For example, some parents did not give inhalers to the school despite being the school policy as inhaler use made the disease visible. The

following conversation between the researcher and the child illustrates the stigma associated with inhaler use.

> So, do you take it [reliever inhaler] with you always, like to the school?
>
> (Researcher)

> School? Oh…No. Mum and dad won't let me. I get picked up if I am unwell.
>
> (C2, 10Y/M)

Family carers were blamed for their child's asthma due to their family history. They were also blamed for adopting Westernised management strategies or were fearful of being blamed for the same.

> Oh…I didn't tell them [extended family members] about it [use of inhalers] because they will be like aah. They will be like stressful, and they will be thinking like…something serious for him.
>
> (P8/Mother)

Family carers were afraid of the possibility of their children getting discriminated against in the Indian community due to their condition. One of the family carers described her experience with asthma.

> Every time in the college and all, I still remember when they go for excursion, I was not at all allowed. When they go for…I mean… for my graduation, we had three days… sorry five days …excursion trip to Place X, Place Y and then my teacher called my parents and told that we won't take you. We don't want to take a risk because they saw, I had a couple of incidents in the college.
>
> (P1/Mother)

Children were underestimated for their skills in doing physical activities and were singled-out during social or cultural gatherings as others tried to overprotect them.

> Yeah. He [child with asthma] gets isolated. That kid can't do anything like that. Kid can't do anything like sports like that.
>
> P4/(Father)

Family carers did everything they could to safeguard their children from the negative connotations associated with asthma. Children received stigma coaching from parents and others in the family.

> Hm…I think when I was in India, some of my relatives used to scare me talking about it…that it is a serious disease, etc. I too was a bit scared. They told me not to tell others about it.
>
> (C9, 13Y/F)

One of the children believed that asthma was contagious and caused by microorganisms that he called 'asthma bugs'. He was brought up by his grandmother, who also believed that asthma was contagious.

> It [the asthma bug] may get out when they talk. Sometimes they can get out when they talk and can spread.
>
> (C8, 8Y/M)

- **Fear of treatment side effects**

Inhaler phobia and steroid phobia were the two most common fears which were dominant among family carers. Some feared inhaler addiction in general, while others were more concerned about the specific side effects associated with preventer inhalers.

> At first, I was not willing to take the inhaler. The main thing is that I was thinking that she will be addicted to that.
>
> (P8/Mother)

Surprisingly, similar views were held even by family caregivers who were registered health professionals such as RNs.

> You know in olden ages, the diseases like this were still there. But you know, there were no inhalers and stuffs but still, people managed. People those days relied on natural remedies, lived long. So, I will prefer it [the inhaler] as a last resort. If we can manage it otherwise, that would be the best thing, I would say. And I also believe that inhalers can also destroy the lung function.
>
> (P9/Mother, an RN)

Children received specific instructions regarding the use of inhalers whose talk reflected the inhaler phobias that were passed on to them.

> Yes, it [inhalers] really helped. But mum does not like me using it. She keeps it with her.
>
> (C10, 12Y/F)

One of the family carers chose to substitute a reliever inhaler for a preventer inhaler for his child due to concerns about the possible side effects of steroids. The child was advised by his family carer to use Ventolin [the reliever inhaler] regularly in the morning.

> My dad is helping me with it [reliever inhaler] in the morning, I go in there with it and I do eye drops and stuffs and then my dad gives me the inhaler every day in the morning.
>
> (C4, 8Y/M)

Despite their concerns about inhalers, most parents agreed that they were effective. Consequently, they were faced with the dilemma of

adhering to an effective treatment while also risking having a negative impact on their children's future in terms of inhaler stigma and side effects on their children's future.

4.2.2 | Category 2: Seeking support

The participants sought support from trustworthy sources, both formal and informal, to overcome their fears. The category of seeking support included two sub-categories: being influenced and making sense.

- **Being influenced**

The participants' attitudes and actions were affected by relatives, friends, community experts, their personal experiences, and the dominant culture in which they socialised. There were positive (e.g. physical and emotional support) and negative (for instance: stigma coaching, conveying myths and misconceptions about asthma) influences from multiple support sources. Children were primarily influenced by their parents, mostly by their mothers. Mothers were usually the primary caretakers for their children's asthma issues, which continued well into adolescence.

Family carers passed on various cultural beliefs to children by sharing their perspectives on asthma.

> They [the child's parents] tell us not to eat very cold things and no drinking cold things like ice and water that makes you very sick.
>
> (C6, 9Y/F)

> She [the child's mother] does all sorts of things and tries to give me God's things from the temple to get rid of it [asthma].
>
> C7, 15Y/M)

Children received support from HCP and maintained a close relationship with them. However, the family carers' influence was stronger than HCP that children finally followed the family carers' decision about asthma management strategies.

> My mom didn't prefer me to use it [the inhaler] as she was telling me that I might get addicted to it. So, I tried it twice, I think the blue one and then I didn't use it afterwards.
>
> (C9, 13Y/F)

Children described the influence of their friends and the support they received from them. Friends became increasingly influential in the teenage years.

> My friends know that I have asthma and I have an inhaler and most of them do know that there are lots of allergies going on and those inhalers are a common thing out here. So, it is not a big deal using it here [in NZ].
>
> (C7, 15Y/M)

Family carers were primarily influenced by their extended family members. They valued the physical, emotional and informational support they received from them.

> I would say Yoga like that…the breathing exercise specifically helps. My aunt got the same similar problem. And she used to take that blue inhaler twice a day. She is a severe asthmatic patient and once she started practicing the Yoga… specially that 'Sudarsanakriya' [a type of Yoga practice] she would… my mum said she is only taking the inhaler hardly two or three times in a month.
>
> (P7/Mother)

Family carers were influenced by their traditional beliefs and practices.

> When she gets flare-ups, we try to manage mostly… what we call like… with the natural remedies like dried ginger powder, ginger coffee like that…and also like orange juice…like that. I always give her vitamin-C based fruits like oranges…all those sorts…I encourage them to take lemon juices.
>
> (P9/Mother)

Parents often sought a second opinion from extended family members or friends regarding the advice provided by HCP.

> Some of my friends, they…. like I mean they told, not them, some of their friends had issues. That is how I realised about the orange inhaler as well…. I told you in the beginning like when the doctor suggested also, we were… like… bit scared…. like… how we will start the orange one… he is a child. Then, they all suggested that it is better to take this.
>
> (P1/Mother)

The power and sources of influence varied as Indian immigrant children and their family carers formed and modified judgements regarding them to achieve their goals. The influence from various support sources formed the basis of how participants made sense of asthma, took decisions and sought further assistance.

- **Making sense**

Making sense refers to how participants accepted and understood asthma. Participants were overwhelmed by the amount of information they received on asthma from multiple formal and informal sources. The participants' reports reflected a feeling of being pulled, pushed and dragged as they tried to make sense of the information from various sources. The strength of the push and pull varied depending on the power of various influences.

> Because three months back, we went to India. Then, everywhere, I was going with this inhaler and then, people saw this [inhalers], and all were asking: Why you are giving this? Why don't you try Homeo and all those things? Then my parents, they said, we never did that [Homeopathy-an alternate system of Indian medicine] with you, and we never gave you that. We went with the modern medicine. So, better you go with that. He [her son] will be fine after some years because that was what happened with me.
>
> (P1/Mother)

> They [the child's mother and grandmother] make me do all the non-sense stuffs. They tell me to do steam with Vicks when I have it [flare-ups], only warm food, and water. Mum gives me that yucky medicine [Ayurvedic cough syrup]. She won't let me use this [puffer]. My doctor gave it to me when I was unwell. It is so cool.
>
> (C8, 8Y/M)

Children and family carers filtered the information they received, developed their own views about the condition, triggers and symptoms, and made choices about management strategies. The following quote by one of the child participants reflected his perspectives on asthma, its impact on his life and the fear of uncertainty.

> Asthma is really bad actually… And people get it… I think… so it is… it is one of those severe conditions where people struggle for breath … For God sake, people don't want to get it… that is the best thing I can say…especially during teenage years….you can't play with your friends… you can't enjoy your life… that is the worst part of asthma… but you are totally fit… it comes as an episode… so you are always waiting for it… you are waiting for that trigger that…so always it will be back in your mind.
>
> (C7, 15Y/M)

Older children's perspectives towards asthma were mainly influenced by the attitudes of their friends who had asthma.

> We notice that most of the Japanese at my age at high school have asthma and my friends…they mostly have asthma as well. Oh…they keep quite ok with that…like …come on…I don't mind at all.
>
> (C3, 16Y/F)

As the children received multiple pieces of advice on the condition, some of the young children developed misunderstandings about asthma and its management. For example, one of the children's talks revealed her confusion over the purpose of preventer inhalers.

> Yes, because we can't use the orange inhaler. Because that means you are feeling good.
>
> (C6, 9Y/F)

Children had diverse opinions about inhaler effectiveness. The way they made sense of inhaler effectiveness had a significant impact on the decisions they took for managing asthma.

> I feel my neck is not blocked anymore. I can breathe in. But I don't like spacer. They tell me to use it. But I am good without it. The orange one helps me normally. But, sometimes, I need the blue one when I do some activities.
>
> (C2, 10Y/M)

One of the child participants, a 16-year-old girl, although aware about the role of a preventer inhaler, preferred to use the reliever inhaler alone as she found the regular use of preventer inhaler as inconvenient.

> Yeah…It is like a stimulator… I think the orange one as the primary one…and the other one as well…I didn't use the orange one because I have to use it every day. I can't bother taking it. Well, they said like it is useful in preventing asthma attacks.
>
> (C3, 16Y/F)

Family carers developed diverse views on asthma. Although they received advice from HCP, they valued advice from their close family members and friends either as equally important or superior to that of health professionals.

> And I have seen my friends' kids got asthma and they are saying their kids having trouble doing certain activities like swimming and other activities where they cannot go and play. Taking those things into considerations, to be honest, we did not send our kid for any strenuous activities just as a precaution. Since we are in a phase like… we both are working and we don't want any struggle within ourselves, so we just don't send her for any activities at this moment. But our doctors told that we can send her to any activities.
>
> (P6/Father)

The participants made sense of asthma based on the stigma existing in the Indian community.

> Yeah, he [her brother] is married. Yeah, now the girl knows that he has these breathing problems sometimes…before marriage, the family…they don't know……we did not inform them. It is a part of our

> stigma. If we have informed them, he won't get any proposal.
>
> (P9/Mother)

4.2.3 | Category three: Clashing cultures

Cultural tension often occurred as the participants attempted to make sense of asthma between Indian and Western views, and the tug-of-war became further intensified as family carers tried to incorporate their beliefs and practices into their children's asthma control strategy. The category of clashing cultures included three sub-categories: feeling conflicted, making negotiations and striving for control.

- **Feeling conflicted**

Family cares' beliefs shaped the context within which children received care. They expressed their shock and surprise as the advice given by the host country's HCP did not match their traditional way of managing the disease. However, children had distinct goals and preferred different strategies to manage asthma compared with their family carers, especially in the case of older children. Children were also confused as they could see their peers adopting a different approach towards asthma while they were trained to approach it in an entirely different way by their parents. Many children were reported to challenge their family carers' views and actions, which were predominantly based on traditional cultural norms and beliefs. Tension arose when family carers disagreed with how their children wished to manage their asthma, resulting in a conflict of interests. Table 2 shows the data segments which refer to the participants' feelings of being conflicted.

- **Making negotiations**

The children and their family carers worked together on how to manage the disease. They made comparisons between Indian and Western approaches in each aspect of asthma care. Family carers developed a personalised management plan after filtering the advice they received from HCP, friends and extended family members and tried to implement it for their children. Their management plans were mostly shaped by the networks of relationships outside the formal health system. They made negotiations with children regarding the approach towards the condition and management strategies. These negotiated understandings determined the children's and family's approach to the condition. The tug-of-war got more intense in this phase.

Family carers in the study tried to retain their grasp on the tug-of-war rope as much as possible by imposing their beliefs and practices onto their children. They were conscious of the areas they were pulling against and relaxed their grasp on some aspects while maintaining a strong grip on others or tugging too hard on the rope. Most family carers, for instance, had rigid rules about inhaler use that they expected their children to follow, based on traditional beliefs. They performed a detailed assessment of the state of their children's' asthma before deciding whether or not to administer inhalers.

> My teacher knows that I have an inhaler at home. I told her the day when I got unwell. Then she wanted

TABLE 2 Quotes illustrating the sub-category of feeling conflicted

Excerpts from children's interview	Excerpts from family carers' interview
'Sam [his friend with asthma] eats ice cream, but my mum will not let me'. (C8, 8Y/M).	'I had this fear that giving him cold foods like ice creams….so I was restricting him [her child with asthma] from all those…… do not give him ice cream. I always used to take out ice cream and keep it in a bowl out for some time to melt, then give him. And every time, he used to ask every time why Master Y [child's brother] gets it in the normal and why when I am getting in this way'. (P1/Mother).
'They [doctors] are funny. They say to use it [preventer inhaler]. But my mum say it is not good.' (C4, 8Y/M).	'I prefer them [her two children with asthma] not to have milk-based products and I tell them the reason that it will increase the phlegm production. But I think the doctors here [in NZ], they recommend giving everything unless they have got any allergy. They do not recommend restricting any type of food for asthma. But I think that [her way of diet modification] has worked for my girls and that is what I have learnt from my experience'. (P9/Mother).
'And you are severely ill in front of people, and you cannot show it [inhaler], and you cannot hide. In that scenario, basically, you have to use it in front of people and there will be talks going on.' (C7, 15Y/M).	'Yeah. yeah… they [HCP] did advise in between. But as we got social stigma that we…if we use the inhaler… it is not good for kids…we did not. (P7/Mother).
'Like a sort of instant relief. I did feel like using it [reliever inhaler] again to get that feel when I again had the same breathing difficulty. I did it again then. Then, my mum advised me to try to avoid it as much and to go with natural remedies first'. (C9, 13Y/F).	'There are different types of inhalers here, I think. Even for a short thing they [General Practitioners] are giving inhalers… First, I also thought like, they will be giving a nebulisation, like one dose of nebulisation. So, I was also thinking that in our country and also in Middle East, we will be giving at least one dose of nebulisation in that emergency department and then the child will be getting the relief'. (P8/Mother).

me to carry it with me as others do. But mum said **NO**. So, I don't carry it.

(C10, 12Y/F)

The following statement from the child's mother provides an explanation for her decision not to provide an inhaler for her child at school, and further demonstrates the stigma that exists in Indian society regarding inhaler use.

No…I have not told them…because I think she is in the stage of outgrowing it…so why we should say them that…it is not that bad…I am not sure if it is asthma or…if we tell them they may treat her like that forever.

(P9/Mother)

Some family carers personalised their children's use of preventer inhalers to minimise the medicine uptake. For example, some parents stopped using preventers when their children were symptom-free but intended to start using them when they were symptomatic or during winter.

He is on that one then and whenever I see any change, you know, or my wife sees any change, then we or any trigger we use the stronger one.

(P4/Father)

Although parents wished to do their best to manage their child's asthma, they had the challenge of meeting societal and cultural expectations regarding asthma which often conflicted with biomedical explanations. The children's goal was to maintain the normalcy of childhood by gaining control over the disease and living a life like their peers. Meanwhile, they were obliged to fulfil parental expectations towards managing the disease. Carers relinquished the hold of the rope in certain elements of asthma care, such as dietary restrictions, based on the negotiations they made with the child. For example, children were allowed to have ice cream or were given melted ice cream when it was summer or when they desperately demanded it. However, the tension around family carer-child decision-making became apparent from family carers' interviews.

I had this fear that giving him cold foods like ice creams….so I was restricting him from all those…… don't give him ice cream. I always used to take out ice cream and keep it in a bowl out for some time to melt, then give him. And every time, he used to ask every time why Master Y [his brother] gets it in the normal way and why when I am getting in this way.

(P1/Mother)

We have stopped giving him dairy products. My son loves dairy products. It is sad that he is not taking dairy products. He is very sad for that.

(P5/Mother)

However, family carers' strategy, on the contrary, was not consistent; it changed depending on the power of the influences at different points in time. Initially, the informal influences mostly pushed them towards a more traditional approach. As children and family carers became more acculturated, they tended to gradually release the rope in favour of Western methods. It was also noted that family carers started to accept Western management strategies either when their traditional management tactics failed or in the case of acute attacks.

No, I have stopped it [Ayurveda] because I do not think it was helping initially. But right now, since I am taking both the medications, I am feeling much better.

(C7, 15Y/M)

And even the pool we had, we did not keep it outside just because of him. But this summer, we allowed him to play in the pool and all. Because so we had the fear that like if he plays in water more, he will have this asthma or if we have more cold food. So, all these things we were restricting him. But now, we don't do any such things.

(P1/Mother)

The authoritarian parenting style did not allow the parents to let go of the rope completely, even with teenagers, while children generally let go of the rope after trying their best to negotiate with carers. One of the family carers explained her rules about restrictions on cold food, which she had asked her children to follow.

I advised them not to have any cold foods especially when they are unwell. They can have cold foods when it is really hot or summer. But when it is winter, a complete no to cold foods.

(P9/Mother)

Her child revealed her attitude towards these restrictions and how she responded to it.

I do feel sad sometimes when I go for a friend's party, also when others are having it. But I am ok with that.

(C9, 13Y/F)

- **Striving for control**

The family carer-child dyad continued working together to gain control over the condition based on the negotiations. The major process observed throughout this phase was a continuous effort to strike a balance between conventional and biomedical approaches to asthma. The following quote reflects one of the family carer's strategies to control his child's asthma, which are mainly centred around traditional beliefs.

That is what I said triggers… keeping that in mind and thinking of that… and we try to avoid cold foods and

> everything. Yeah, we try to keep her and follow the same. During this period [time of asthma flare-ups], we normally keep her warm as much as possible, even warm food, nothing from the fridge straight. We try to avoid all those foods and my parents used to say they offer prayers. Back in India, we offer prayers like if you have got some sort of a disease. They go to temple and offer prayers and they believe while doing these things, get the disease cured. As you could see, she has got a red string on her arm.
>
> (P6/Father)

Family carers adopted a trial-and-error approach to managing their child's asthma, and the child became a victim of it. Most family carers tried experimenting with Complementary and Alternative Medicine (CAM) until the child's asthma became worse. One of the family carers, who was an RN, chose a traditional approach to asthma management for her two children. She preferred her children to use inhalers only as a last resort.

> She gets flare-ups, but it is not as worse as when we were in India. Yeah…she has used it twice or thrice just like C9 and she knows how to use it. But I told her.... I advised her... so they knew the pros and cons. So, I think.... maybe two months ago she had like mild cold and fever along with mild flare-ups... yeah, but we managed with all our natural remedies and stuffs. You know that I make sure that they are fine and well enough. In such a case, they do not have to go to a stage where they have to use the inhalers.
>
> (P9/Mother)

Children, regardless of their age, relied on their family carers to help them plan strategies to control their asthma. Children gradually learnt and acquired the confidence to autonomously self-manage asthma through their personal experiences and self-experimentation, while also mirroring their family carers' asthma management strategies. They explained their various strategies to gain control over the disease.

> Yeah, like when I am unwell. I stay away from activities. I carry my blue inhaler to the activities sometimes as a precaution. But I never had to use it. I try not to use it, but to be on the safe side, I carry it. But if I am unwell, I don't go to the activities. Avoid the triggers. We have to look after ourselves. Try to avoid milk products and cold food. Whenever I get fever, we go to the doctors and try to sort it early and that it doesn't flare up my asthma. That's about it. Also, oranges help, steam inhalation.
>
> (C9, 13Y/F)

> The orange one helps me normally. But, sometimes, I need the blue one when I do some activities.
>
> (C2, 10/M)

> When I always wake up in the morning, I get my inhaler. The inhaler always stays at home and when we go out, we take the inhaler. I take honey and avoid milk.
>
> (C5, 9Y/M)

Children and their family carers described how their immigrant status impacted their effort to acquire control over asthma. Issues related to acculturation, such as lack of extended family or wider community support, lack of confidence in the NZ healthcare system, language barriers, financial constraints and changes in gender roles, were some of the primary challenges (see Table 3).

5 | DISCUSSION

Navigating asthma: the immigrant child in a tug-of-war, explains the challenges faced by Indian immigrant children and their family carers as they construct and negotiate their understanding of asthma influenced by their Indian heritage within the Western healthcare context. Our study results showed that the familial, cultural, and societal norms about asthma played a key role in determining how the participants viewed the condition, interpreted the causes and symptoms, planned the management strategies, and utilised healthcare. The findings extend and link to the existing literature which associates health disparities among Indian immigrants to beliefs and practices that contradict the evidence-based advice of HCP (Heer et al., 2015; Lakhanpaul et al., 2017; Mehrotra et al., 2014; Mufti et al., 2015; Ravindran & Myers, 2012; Theara & Abbott, 2015). Findings supporting this notion are evident from Lakhanpaul et al.'s (2014) systematic review which explored barriers to asthma management among SA immigrants which reported most of them to be culturally driven. This included denial of the disease, diverse beliefs regarding the cause and nature of asthma, under-use of preventer medications (due to fear of addiction and side effects), language barriers, use of complementary and alternative therapies and the impact of prejudice and stigmatisation.

Although migration may affect the socialisation practices of immigrant Indian families, extant literature shows that their ties to Indian culture may remain strong in all aspects of their post-migration lives, including childrearing (Chadda & Deb, 2013; Nayar, 2011). The tug-of-war we observed is linked to Indian immigrants' efforts to preserve their strong collectivistic cultural orientation, which emphasises collective needs and expectations of the family, community and society over individual preferences (Nayar, 2011; Raina et al., 2020). Migration studies have shown that people's transitions from a primarily collectivistic society to an individualistic community are likely to be challenging, particularly if they continue to maintain

TABLE 3 Quotes referring to challenges associated with acculturation in striving for control towards asthma

Excerpts from children's interview	Excerpts from family carers' interview
'If I was in India, my grandpa & grandma could help me.' (C1, 8Y/M).	'I had to come back because we only have one car and I have to bring the car and he has trouble in communicating the issues. So, I took sick leave on that day. So, it affects our family as a whole when they are unwell.' (P9/Mother).
'In the case of hospitals here [in NZ], it is really hard to get into the emergency, the waiting time is too much. I had to wait like hours and hours when I was having severe fever and chest infection along with my asthma flare-ups'. (C9, 13Y/F)	'You cannot cope with one person's earning here. That is another really struggling part. So, both have to go to work. We really struggled last couple of times when she was unwell'. (P6/Father).
'But sometimes like as my mom said they are just giving you like the same medication for everything… With GP you can go only for like minor things. Asthma and like allergies. I feel you need to go to a specialist'. (C3, 16Y/F)	'But in India, we got so many treatment…you got another one…another one…you can see lots of things in India… so we keep trying like this one not working…you can try other things like… Homeopathy, Allopathy, Ayurveda…but, in here [NZ], you can only go to GPs.' (P3/Mother).
	'Yeah…plenty of people would be there [in India] to look after. Yeah…yeah…definitely. So, that is the drawback we have here [NZ]'. (P4/Father).

collectivistic views (Joseph et al., 2020). For example, the stigma associated with asthma in the Indian community restricted children's inhaler use in public because they were afraid of being judged by people from their community. Similarly, many Indian immigrant families face challenges in inculcating traditional health practices and beliefs in their children to function effectively to meet the expectations of their local communities in the host country (Raina et al., 2020).

Indian immigrant children growing up in a Western health culture might not always understand some of these beliefs, causing confusion for them (Nayar, 2011; Raina et al., 2020). The current study also revealed similar tensions in the family carers' attempts to transmit their beliefs, practices and societal expectations about asthma to their children while offering them a lens through which to interpret asthma care decisions. For instance, most parents strongly believed in the hot-cold theory of illness, which posits that asthma occurs when the body's equilibrium is disturbed by being excessively hot or cold (Ramdzan et al., 2019). This belief, based on Ayurveda, India's traditional medicine, was confusing to children because it differed from Western concepts that had no hot-cold restrictions in asthma management. The pressure to meet the expectations of their parents to manage the disease made the situation more complex, intensifying the tug-of-war. Studies have shown that parental influence over children appears to be greater in Indian immigrants than in the general population because of their authoritarian parenting style, even when teenage children are involved (Sondhi, 2017).

Parents who practise authoritarian parenting expect their children to obey them, depend on them and work with them on all issues that affect them (Kuppens & Ceulemans, 2019; Sudarsan et al., 2022c). For example, Indian family carers in the study had rigid beliefs about inhaler use; they modified their child's inhaler use to minimise medicine uptake or substituted it with various CAM therapies because they believed that the latter had fewer side effects than the former. Children who were forced to follow their parents' beliefs expressed a sense of being different as they received conflicting advice from HCP and watched their peers do it differently. Berry (1980) states that individuals may suffer from acculturative stress when faced with problems arising from intercultural interactions. The study findings also revealed that the family caregivers struggled to cope with the competing demands of caregiving in the absence of extended family support, balancing daily life pressures in a foreign country and adjusting to the NZ healthcare system.

To the best of our knowledge, the current study is the first to explore Indian immigrants' childhood asthma experiences. Previous studies on childhood asthma in other immigrant groups were largely based on the experiences of family caregivers (Lakhanpaul et al., 2019). It is important to remember that children perceive and experience the world differently from adults. Any therapeutic intervention designed for children should account for these differences. Our GT study reflects both the experiences of the children and those of their family carers in their broader, complex sociocultural environment. Article 3 of the UNCRC states unequivocally that 'all organisations concerned with children should work towards what is best for each child' (UNICEF, 2006, p.1). Practice can be advanced in the best interests of the child only if the child's experiences of asthma are explored (Lakhanpaul et al., 2019).

This GT study provides new insights into the challenges faced by Indian immigrant children during their asthma journey, as described by the children themselves. According to the theory, various tug-of-wars occur within various domains of asthma management. This theory raises concerns regarding children's exclusion from asthma care decisions by their family caregivers, close relatives and HCPs. While children observed the adults around them collaborating and forming partnerships in terms of asthma care, they reported that they were unable to participate in their own care and were frequently passive observers. If children are not allowed to participate in their own healthcare, they may experience fear, anxiety and prolonged emotional trauma as they try to navigate a complex system of healthcare (Barratt et al., 2022). While existing literature indicates the importance of letting family caregivers retain control over their children's asthma, our study emphasises the importance of giving children a sense of agency and power over their own healthcare. Further, the theory offers insights for HCPs not only in the context of Indian immigrants but also in other ethnic and cultural contexts for developing

culturally appropriate interventions to improve asthma management among immigrant families.

6 | LIMITATIONS

The study was a small qualitative study which included nine children and ten family carers and was restricted to City X in NZ. All the family carers were the children's parents, and most of them were mothers. The study excluded family carers and children who did not speak English. As Indians speak a variety of languages, it would have been necessary to hire multiple translators if non-English-speaking Indian immigrants had participated in the study. Furthermore, the translation process can be time-consuming and costly, and it may jeopardise the accuracy of the data due to the possibility of meaning loss during the translation process (Nurjannah et al., 2014). Considering the reasons above, and as a novice GT researcher, IS found it challenging to include non-English-speaking Indian immigrants in the current study.

As the study followed a CGT approach which included the reflexive engagement of the researcher, the resultant CGT is a constructed portrayal of the asthma experience of children and their family carers by the researchers. Therefore, different researchers would probably construct alternative codes and categories even under similar circumstances. Moreover, the theory is contextually positioned in time, place, culture and situation and may not be transferable to other similar populations (Charmaz, 2014). Despite these limitations, the quality and amount of data enabled us to address the research aim credibly.

7 | CONCLUSION

The findings of the study suggest that the experiences of Indian immigrant children and their family carers in NZ are distinct from those of the general population and may be influenced by several variables such as acculturation and sociocultural factors. To effectively plan and implement culturally congruent asthma management strategies, family carers and children must be involved in decision-making and recognised for their expertise. The theory provides a basis for service providers and practitioners to better understand Indian immigrant children's and their family carers' asthma experiences within their wider sociocultural context. The theory may have relevance and be applied in other similar contexts of healthcare.

8 | RELEVANCE TO CLINICAL PRACTICE

8.1 | Culturally safe nursing care

A key element in ensuring high quality transcultural nursing care is improving nurse's skills to provide culturally safe care (Curtis et al., 2019; Westenra, 2019). The goal of culturally safe nursing care is to provide safe and effective care to all people while maintaining their personal, cultural and social identities. Providing culturally safe care requires that nurses examine their attitudes towards each new individual they encounter while practising and approaching them in a non-judgemental and open manner. As nurses become more aware of their assumptions, stereotypes, biases and prejudices, they will be able to communicate more effectively with the people they care for (Curtis et al., 2019).

8.2 | Collectivistic approach to nursing care

Nurses may consider adopting a collectivist approach when providing care to Indian immigrant families. Engaging with family members and other essential members of the community in asthma education, may change behaviours more effectively than an individualistic approach. If Indian immigrants can maintain cultural ties either through better social support or by maintaining cultural practices, then cultural bereavement may be minimised (Wojcik & Bhugra, 2010). We recommend that community members who are trustworthy, reliable, culturally competent and able to identify with Indian immigrant families be hired by child healthcare services to help them meet the cultural needs of Indian immigrant families, explain local policies and services, and assist families understand the services their children receive (Karim et al., 2020).

8.3 | Child inclusive nursing practice

Nurses should collaborate with both family caregivers and children to develop effective asthma management strategies. This approach provides opportunities for both parties to participate in decision-making regarding the child's asthma care, thereby improving family outcomes. If, on the contrary, this partnership is adult-centric, children may lose their voice to the heavy voices of adults, thus resulting in an imbalance of power that may negatively affect them as they mature and seek more control and knowledge over their own health care (Barratt et al., 2022). Future research should therefore focus on developing policies that promote the active participation of children in their asthma care planning.

ACKNOWLEDGEMENTS

The authors wish to acknowledge Massey University for the doctoral scholarship awarded to the first author, Indu Sudarsan. Open access publishing facilitated by Massey University, as part of the Wiley - Massey University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

FUNDING INFORMATION

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

PATIENT/PUBLIC CONTRIBUTION

The developed theory is grounded in the data collected from the participants.

ORCID

Indu Sudarsan https://orcid.org/0000-0002-1954-3094

REFERENCES

Ahmed, S., Steed, L., Harris, K., Taylor, S. J., & Pinnock, H. (2018). Interventions to enhance the adoption of asthma self-management behaviour in the South Asian and African American population: A systematic review. *Primary Care Respiratory Medicine*, *28*(1). https://doi.org/10.1038/s41533-017-0070-6

Barratt, M., Bail, K., & Paterson, C. (2022). Children living with long-term conditions and their experiences of partnership in nursing care: An integrative systematic review. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.16429

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*. Penguin Books.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. M. Padilla (Ed.), *Acculturation: Theory, models, and some new findings* (pp. 9–23). Westview Press.

Birks, M., & Mills, J. (2020). Rendering analysis through storyline. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of current developments in grounded theory* (pp. 243–258). SAGE Publications Ltd.

Chadda, R., & Deb, K. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian Journal of Psychiatry*, *55*(2), 299. https://doi.org/10.4103/0019-5545.105555

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). Sage Publications.

Curtis, E., Jones, R., Tipene-Leech, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(174). https://doi.org/10.1186/s12939-019-1082-3

Heer, K., Larkin, M., & Rose, J. (2015). The experiences of British SA carers caring for a child with developmental disabilities in the UK. *Tizard Learning Disability Review*, *20*(4), 228–238. https://doi.org/10.1108/tldr-12-2014-0044

Joseph, A., Jenkins, S. R., Wright, B., & Sebastian, B. (2020). Acculturation processes and mental health of Asian Indian women in the United States: A mixed-methods study. *American Journal of Orthopsychiatry*, *90*(4), 510–522. https://doi.org/10.1037/ort0000465

Kanengoni, B., Andajani-Sutjahjo, S., & Holroyd, E. (2018). Setting the stage: Reviewing current knowledge on the health of New Zealand immigrants: An integrative review. *PeerJ*, *6*, e5184. https://doi.org/10.7717/peerj.5184

Karim, N., Boyle, B., Lohan, M., & Kerr, C. (2020). Immigrant parents' experiences of accessing child healthcare services in a host country: A qualitative thematic synthesis. *Journal of Advanced Nursing*, *76*(7), 1509–1519. https://doi.org/10.1111/jan.14358

Kuppens, S., & Ceulemans, E. (2019). Parenting styles: A closer look at a well-known concept. *Journal of Child and Family Studies*, *28*(1), 168–181. https://doi.org/10.1007/s10826-018-1242-x

Lakhanpaul, M., Bird, D., Manikam, L., Culley, L., Perkins, G., Hudson, N., Wilson, J., & Johnson, M. (2014). A systematic review of explanatory factors of barriers and facilitators to improving asthma management in South Asian children. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-403

Lakhanpaul, M., Culley, L., Huq, T., Bird, D., Hudson, N., Robertson, N., McFeeters, M., Manikam, L., Johal, N., Hamlyn-Williams, C., & Johnson, M. R. (2019). Qualitative study to identify ethnicity-specific perceptions of and barriers to asthma management in South Asian and white British children with asthma. *BMJ Open*, *9*(2), e024545. https://doi.org/10.1136/bmjopen-2018-024545

Lakhanpaul, M., Culley, L., Robertson, N., Bird, D., Hudson, N., Johal, N., McFeeters, M., Angell, E., Hamlyn-Williams, C., Abbas, N., Manikam, L., & Johnson, M. (2017). A qualitative study to identify parents' perceptions of and barriers to asthma management in children from South Asian and white British families. *BMC Pulmonary Medicine*, *17*(1), 126.

Mehrotra, N., Ramagopal, M., & Dodani, S. (2014). Cultural factors impacting asthma management in Asian Indian children. *Indian Journal of Allergy, Asthma and Immunology*, *28*(2), 63–67. https://doi.org/10.4103/0972-6691.140761

Mehta, S. (2012). Health needs assessment of Asian people living in the Auckland region. https://countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/2012-health-needs-of-asian-people.pdf

Mufti, G., Towell, T., & Cartwright, T. (2015). Pakistani children's experiences of growing up with beta-thalassemia major. *Qualitative Health Research*, *25*(3), 386–396. https://doi.org/10.1177/1049732314552663

Nayar, S. (2011). Settling in New Zealand: The well-being of Indian immigrant women as shaped by their children. *Diversity in Health and Care*, *8*(2), 93–101.

Nurjannah, I., Mills, J., Park, T., & Usher, K. (2014). Conducting a grounded theory study in a language other than English. *SAGE Open*, *4*(1), 215824401452892. https://doi.org/10.1177/2158244014528920

O'Connell, S., McCarthy, V. J., Queally, M., & Savage, E. (2021). The preferences of people with asthma or chronic obstructive pulmonary disease for self-management support: A qualitative descriptive study. *Journal of Clinical Nursing*, *30*(19–20), 2832–2841. https://doi.org/10.1111/jocn.15790

Parackal, S., Coppell, K., Yang, C. L., Sullivan, T., & Subramaniam, R. M. (2021). Hidden figures and misnomers: a case for disaggregated Asian health statistics in Aotearoa New Zealand to improve health outcomes. *The New Zealand Medical Journal (Online)*, *134*(1546), 109–116.

Plunket. (2015). The Asian peoples strategy 2015–2020: The draft. https://www.plunket.org.nz/assets/PDFs/asian-strategy-draft.pdf

Raina, M., Ollier-Malaterre, A., & Singh, K. (2020). Happily exhausted: Work family dynamics in India. *Occupational Health Science*, *4*(1–2), 191–211. https://doi.org/10.1007/s41542-020-00059-0

Ramdzan, S. N., Pinnock, H., Liew, S. M., Sukri, N., Salim, H., Hanafi, N. S., Hussein, N., Suhaimi, J., Lee, P. Y., Cheong, A. T., Ahad, A. M., Cunningham, S., & Khoo, E. M. (2019). Perceptions of complementary/alternative medicine use and influence on evidence-based asthma medicine adherence in Malaysian children. *npj Primary Care Respiratory Medicine*, *29*(1). https://doi.org/10.1038/s41533-019-0118-x

Ravindran, N., & Myers, B. J. (2012). Beliefs and practices regarding autism in Indian families now settled abroad: An Internet Survey. *Focus on Autism and Other Developmental Disabilities*, *28*(1), 44–53. https://doi.org/10.1177/1088357612458970

Schlichting, D., Fadason, T., Grant, C. C., & O'Sullivan, J. (2021). Childhood asthma in New Zealand: The impact of on-going socioeconomic disadvantage (2010–2019). *The New Zealand medical journal*, *134*(1533), 80–95.

Scragg, R. (2016). Asian health in Aotearoa in 2011-2013: Trends since 2002-2003 and 2006-2007. https://www.ecald.com/assets/Resources/Asian-Health-Aotearoa-2011.pdf

Singh, S., & Estefan, A. (2018). Selecting a grounded theory approach for nursing research. *Global Qualitative Nursing Research*, *5*, 2333393618799571. https://doi.org/10.1177/2333393618799571

Sondhi, R. (2017). Parenting adolescents in India: A cultural perspective. In M. H. Maurer (Ed.), *Child and adolescent mental health* (pp. 91–108). InTechOpen. https://doi.org/10.5772/66451

Stanojevic, S., Shah, B. R., Anand, S. S., Sears, M. R., Su, J., & Subbarao, P. (2014). The burden of asthma among south Asian and Chinese populations residing in Ontario. *Canadian Respiratory Journal*, *21*(6), 346–350. https://doi.org/10.1155/2014/160476

Sudarsan, I., Hoare, K., Sheridan, N., & Roberts, J. (2022a). Positioning the researcher for studying Indian immigrant children's asthma in New Zealand: A reflective account. *Qualitative Research Journal*, *22*(3), 378–390. https://doi.org/10.1108/qrj-08-2021-0091

Sudarsan, I., Hoare, K., Sheridan, N., & Roberts, J. (2022b). South Asian immigrants' and their family carers' beliefs, practices and experiences of childhood long-term conditions: An integrative review. *Journal of Advanced Nursing*, *78*(7), 1897–1908. https://doi.org/10.1111/jan.15217

Sudarsan, I., Hoare, K., Sheridan, N., & Roberts, J. (2022c). Giving voice to children in research: The power of child-centered constructivist grounded theory methodology. *Research in Nursing & Health*, *45*(4), 488–497. https://doi.org/10.1002/nur.22231

Theara, G., & Abbott, D. W. (2015). Understanding the experiences of SA parents who have a child with autsim. *Educational and Child Psychology*, *32*(2), 47.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

United Nations International Children's Emergency Fund. (2006). A simplified version of the United Nations Convention on the Rights of the Child. https://www.unicef.org.au/upload/unicef/media/unicef-simplified-convention-child-rights.pdf

Westenra, B. (2019). A framework for cultural safety in paramedic practice. *Whitireia Nursing and Health Journal*, *26*, 11–17.

Wojcik, W., & Bhugra, D. (2010). Loss and cultural bereavement. In *Mental health of refugees and asylum seekers*. Oxford University Press.

Wong, A. (2015). Challenges for Asian health and Asian health promotion in New Zealand. http://www.hauora.co.nz/assets/files/Occasional%20Papers/15128%20%20FINAL%20%20Health%20promotion%20forum%20Asian%20promotion

Wong, S., &Tsang, B. (2018). Caring for Asian children. https://www.ecald.com/assets/Resources/Assets/cald-asian-children.pdf

World Health Organisation. (2021). Asthma. https://www.who.int/news-room/fact-sheets/detail/asthma

Yong, S. (2018). An Asian perspective and the New Zealand treasury living standards framework (DP 18/10). The Treasury. http://treasury.govt.nz/publications/dp/dp-18-10-html

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Sudarsan, I., Hoare, K., Sheridan, N., & Roberts, J. (2023). Navigating asthma—the immigrant child in a tug-of-war: A constructivist grounded theory. *Journal of Clinical Nursing*, *32*, 4009–4023. https://doi.org/10.1111/jocn.16521