



# Health and Health Care of Filipino American Older Adults

<http://geriatrics.stanford.edu/ethnomed/filipino>



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## DESCRIPTION

This module presents information that is available related to health status and health care of older adults from Filipino backgrounds in the US. It includes some background on the population and traditional health beliefs as well as important clinical considerations.

### Course Director and Editor in Chief of the Ethnogeriatrics Curriculum and Training

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### MODULE CHARACTERISTICS



**Time to Complete:** 2 hrs, 0 mins



**Intended Audience:** Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



**Peer-Reviewed:** Yes

## LEARNING OBJECTIVES

After completion of this module, learners will be able to:



1. Describe major socio-demographic information of the Filipino American community with special emphasis on Filipino American older adults.
2. Identify significant historical and sociopolitical events that influenced the immigration of Filipino older adults to the U.S.
3. Identify the major sources of available health data related to mortality and morbidity rates, and health-related issues Filipino American older adults.
4. Describe common living arrangements and patterns of social support available to frail and disabled Filipino American older adults.
5. Identify at least five critical areas for health assessment, screening, and intervention for Filipino American older adults.
6. List five cultural factors that may potentially influence the health behaviors of Filipino American older adults and their clinical interactions.
7. List at least five culturally acceptable approaches that clinicians can use to skillfully facilitate communication with Filipino American older adult patients and their families.

## INTRODUCTION AND OVERVIEW

### Demographics

Based on the 2008 American Community Survey 1 year estimation, Filipino Americans (alone or in combination with one or more races) account for merely 1%–1.5% of the total US population (US Census Bureau, 2008a). However, they are the second largest Asian American group after Chinese Americans. The subgroup of Filipino American older adults (defined as age 65 and over in this chapter) accounts for 9.9% of the total Filipino American population. An estimated 35.4% of Filipino American older adults are disabled. Filipino Americans are fairly widely dispersed in the United States. California holds the largest Filipino American settlement, followed by Hawaii, Illinois, New Jersey, New York, Washington State, Texas, Florida, Virginia, and Nevada respectively (US Census, 2000).

Between 1986 and 2006 the number of Filipino immigrants tripled, making them the second largest immigrant group in the US after Mexican immigrants. Almost half the Filipino immigrants reside in California. An estimated one third of Filipino immigrants in 2006 have limited English proficiency (Terrazas, 2008).

The median household income of Filipino Americans is \$74,983 (US Census Bureau, 2008a) and this is 25% more than the national average.

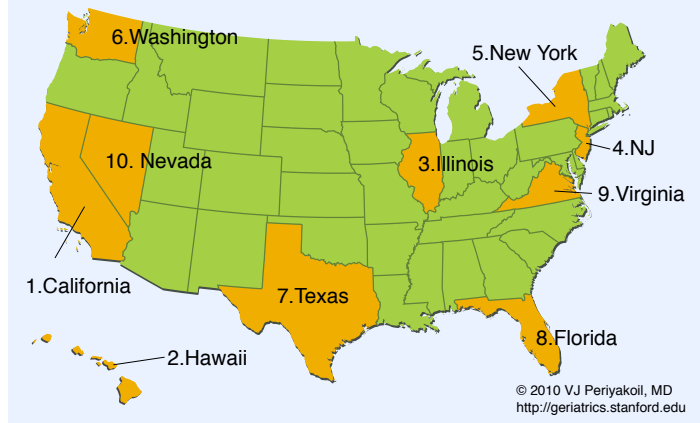
The poverty rate of Filipino Americans is less than half that of the national total population. The poverty rate among Filipino Americans aged 65 years and older is lower (7.7%) than that of the total US geriatric population (9.5%). It is also lower than the poverty rate of other elder Asian Americans with the exception of Japanese Americans (7.3%) (US Census Bureau, 2008b).

Among Asian Americans, Filipino American households have one of the highest proportions of owner-occupied homes (63.6%), only slightly lower than that of all US households (66.6%). A typical Filipino American household consists of 3 or more persons on average and has one of the lowest percentages of non-family households (23.3%) among Asian American populations.

### FAST FACTS

- In 2008, Filipino Americans accounted for 1%–1.5% of the total U.S. Population
- The median household income of Filipino Americans is 25% more than the national average.
- Filipino Americans have the highest percentage (27%) among Asian Americans of grandparents living with and caring for their grandchildren who are under 18 years of age.

### Filipino American Population by State



A non-family household may contain only one person—the householder (person in whose name the housing unit is owned or rented)—or additional persons who are not relatives of the householder. Non-family households may be classified as either female non-family or male non-family households (Bryson, 1998). Many of these households are inter-generational in which grandparents often serve as surrogate parents for young children. In fact, Filipino American immigrants have the highest percentage (27%) among Asian Americans of grandparents living with and caring for their grandchildren who are under 18 years of age (US Census Bureau, 2008c).



## (INTRODUCTION AND OVERVIEW CONT'D)

## Language

### In the Philippines

Filipino, or Tagalog, is the national language of the Philippines. English was introduced into the Philippines during the US colonial occupation and civil regime in the early 1900s and has now become the second official language. In fact, Tagalog and English compete in the various domains of Filipino society such as business, government, broadcast media, publications, and education. English words have been assimilated into Tagalog to create a blended hybrid, or slang, known as “Taglish”. The significant penetration of the English language into the Philippines has resulted in a strong similarity between the Philippine and American educational systems. This similarity has enabled Filipino Americans to transition easily and become absorbed seamlessly into the United States workforce.

### Other Dialects

In addition to Tagalog, there are over 100 ethnic dialects spoken in the different parts of the Philippines. Of these, ten are considered major dialects. The Philippine National Statistics Office (Philippine Census, 2000) estimates that Tagalog is the predominant language spoken, followed by Cebuano, Ilokano, Hiligaynon, Waray-Waray, Kapampangan, Chavacano, Northern Bicol, Pangasinan, and Southern Bicol respectively.

### In the US

An estimated 42.6% of Filipino Americans speak only English at home, while the rest speak other Filipino dialects at home in conjunction with fluid English (57.4%) (US Census Bureau, 2008a). Though many Filipino American older adults can communicate in English, they typically prefer to speak their native language, particularly when ill or when in other high stress situations.

“ Though many Filipino American older adults can communicate in English, they typically prefer to speak their native language, particularly when ill or when in other high stress situations. ”

## Religion

### Christianity

The Philippines is the only country in Asia in which Christianity is the national religion. This is probably the result of the Spanish Catholic reign in The Philippines for more than 300 years. Religion still plays a central role in the lives of most Filipino Americans.

An estimated 92.5% of Filipinos are Christians; the major Christian denominations are as follows:

1. Roman Catholic (80.9%),
2. Evangelical (2.8%)
3. Iglesia ni Cristo (2.3%)
4. Aglipayan (2%)
5. Other Christian groups (4.5%) including Protestant, Baptist, Pentecostal, Anglican, Orthodox, Methodist, and Seventh Day Adventist.

### Islam and Other Religions

Approximately 5% of the population is Muslim, mostly concentrated in the Southern Philippines, especially on Mindanao Island. 1.8% of the population subscribes to other independent religions, while 0.7% does not practice or belong to any religious affiliation (Central Intelligence Agency, 2010; Philippine Census, 2000).

## PATTERNS OF HEALTH RISK

### Health Status: Morbidity and Mortality

Ranked Leading Causes of Death Among Filipino American Older Adults 65 years and older:

1. Cardiovascular Disease
2. Malignancy
3. Stroke
4. Chronic Lower Respiratory Disease (COPD) and Asthma
5. Diabetes Mellitus
6. Influenza and Pneumonia
7. Nephritis, Nephrotic Syndrome, and Nephrosis
8. Accidents (Unintentional Injuries)
9. Aortic aneurysm and Dissection
10. Hypertension and Hypertensive Renal Disease (Huo, 2009).

### Cardiovascular Disease and Diabetes

A cross-sectional study of Filipino American women (N=389) in San Diego County between 1995 and 1999 showed that being socially disadvantaged during childhood, a family history of diabetes, and a larger waist circumference were significant predictors of diabetes occurrence, while factors limiting early growth of the legs may increase the risk of coronary heart disease (Langenberg, 2007).

A study of Filipino American patients (N=527) in Daly City, CA between 1992 and 1996 showed that this population has a higher incidence of hypertension and diabetes compared to its Caucasian counterparts (n=3,176). Being of Filipino American ethnicity was also found to be an independent predictor of death after a catheterization laboratory intervention, an emergency procedure, a depressed ejection fraction, a history of myocardial infarction and age greater than 65.

“ A cross-sectional study of Filipino American women (N=389) in San Diego County between 1995 and 1999 showed that being socially disadvantaged during childhood, a family history of diabetes, and a larger waist circumference were significant predictors of diabetes occurrence... ”

The need for any re-intervention was significantly higher among the Filipino American group compared to the Caucasian group (Ryan, 2000).

A cross-sectional survey conducted among Filipino Americans (N=831) in Houston, Texas between 1998 and 2000 showed a high prevalence of type 2 diabetes compared to the US non-Hispanic white population, especially among the elderly. The independent risk factors were a family history of diabetes, male sex, obesity, and Mindanao as region of birth (Cuasay, 2001).

A cross-sectional study from 1992 to 1999 in San Diego County between two groups of community dwelling women aged 50 – 69 showed that the Filipina American Group (N=294) had a higher prevalence of type 2 diabetes by oral glucose tolerance test criteria and more features of the metabolic syndrome as compared to their Caucasian counterparts (N=379) (Araneta, 2002).

Filipino Americans exhibit significantly higher levels of hypertension than other Asian Americans. These levels are similar to those of African Americans who live in the US (President's Advisory Commission on Asian Americans and Pacific Islanders, 2003).

### Chronic Kidney Disease

An epidemiologic study among Asian Americans in Hawaii between 2001 and 2003 showed that Filipino

### (PATTERNS OF HEALTH RISK CONT'D)

Americans were at increased risk for developing chronic kidney disease if they were age 65 or older, or had hypertension or diabetes mellitus (Mau, 2007).

### Cancer

Filipino American women, including the elderly, have the second highest incidence and the highest mortality rate for breast cancer compared with other Asian American ethnic groups. Established risk factors include obesity, acculturation and the adoption of westernized diet and behaviors. Filipino American men, including the elderly, have the highest incidence and death rate from prostate cancer among Asian American groups. They also have the second highest incidence and the highest mortality rate from lung cancer among Asian American groups. Filipino Americans have among the lowest screening rates and incidence for colorectal cancer among Asian American groups (McCracken, 2007).

Filipinos have the second poorest five-year survival rates for colon and rectal cancers of all US ethnic groups (Miller, 1996).

In regards to other cancer, the incidence of liver cancer in Filipino populations is higher than rates among Caucasians (Cooper, 1997). [MSG2] They also have shortest and worst survival rates for gastric cancer (instead of bladder cancer) compared to other Asian ethnic groups and their Caucasian counterparts (Kim, 2009). Finally, Filipino populations have the shortest median survival and worse survival for bladder cancer compared to other Asian ethnic groups (Hashibe, 2003).

Foreign-born Asians, including Filipinos, have an approximately 35% higher rate of non-small-cell lung cancer than US-born Asians. This fact may be due to the increased prevalence of smoking habits among Foreign-born Asian men compared to their US-born Asian men counterparts. For foreign-born Asian women, environmental tobacco or non-tobacco exposure puts them at a higher risk for non-small cell lung cancer. (Raz, 2008).

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### Dementia

Data regarding the prevalence of dementia among elderly Filipino Americans is limited, most probably because of minimal case findings.

### Depression and Suicides

Separation from family, economic hardship and geographic isolation are common stressors among Filipino Americans with clinical depression (Tompar-Tiu & Sustento-Senneriches, 1995).

Many Asians, including Filipino Americans, either unconsciously or consciously conceal the experience and expression of their emotions, finding it more acceptable to express psychological distress through bodily symptoms (somatization) rather than by mental or emotional means (Chun, 1996).

Compared with other Asian minorities, Filipino Americans were found to have a lower incidence of suicide because of the influence of Catholicism and the availability of extended family and social support systems (Grudzen & Mc Bride, 2001).

A pilot study conducted at a senior community center in Queens, NY revealed that 15% of the senior Filipino population is moderately or severely depressed. A lower incidence of depressive symptoms was strongly correlated with a higher quality of life, and the level of depression as a powerful predictor of the degree of life

**(PATTERNS OF HEALTH RISK CONT'D)**

satisfaction (Asian American Federation of New York, 2003).

**Elder Abuse**

Based on the reports of elder abuse filed with Adult Protective Services for several Northern California Counties, one of the most vulnerable groups is recent WWII Filipino veteran immigrants who relocated to the US in 1990 to become naturalized, but were not entitled to veterans' benefits. In the San Francisco Bay Area, 12 elderly veterans who were living under severe oppressive conditions came to the attention of Adult Protective Services through an investigative report. Action from the Filipino Community contributed greatly to the correction of the problem (Chin, 1993a,b).

Admittedly, there is very little to non-existent research on this important issue. However, elder abuse is typically under reported and under treated and we suspect this to be the case for Filipino American older adults as well. Unfortunately, the patients and families involved in such cases are uninformed about available resources and believe that caring for the elder is their responsibility (Lewis, Sullivan & McBride, 2000). More research is certainly needed to gain a better understanding of this important issue.

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**Gout**

Hyperuricemia and gout have been recognized among the Filipinos in Hawaii, Alaska, and mainland United States for almost two decades (Torralba & Bayani-Soison, 1975). Due to the lack of adequate research, we are unable to comment on the broader clinical impact (if any) of this problem.

**Osteoporosis**

Although Asian women including elderly Filipinos are considered at high risk for osteoporosis, health data remained scarce, especially in postmenopausal women. Lack of referent databases for Asian American women has also resulted in inconsistent data about their risk status and diagnostic criteria (Walker, 2006).

**Infectious Disease: Tuberculosis and HIV**

According to the Centers for Disease Control and Prevention, more than half of TB cases in the US in 2008 were found in foreign-born individuals, with immigrants from the Philippines ranked second behind those from Mexico (CDC, 2008a). Asian Americans and Pacific Islanders comprised 0.6% of the total US population living with HIV/AIDS in 2005 (CDC, 2008b). Little is known about the number of elderly Filipino Americans living with HIV.

**Functional Status**

Small studies among elderly Filipino Americans showed that the effect of chronic co-morbidities can have an impact on their functional status and ability.

In a small study of Asian American older adults in New York City, Filipino older adults (N=52) claimed the second lowest number of ADL impairments (0.2) compared to other Asian ethnic minorities (Asian American Federation of New York, 2003), and the second lowest number of medical problems (2.2) after Japanese older adults (Asian American Federation of New York, 2003). Using SF-36 Quality of Life Sub-Scales, Filipino older adults reported having the best general health, vitality, social functioning, quality of



### (PATTERNS OF HEALTH RISK CONT'D)

life, and mental health compared with other Asian American groups (Asian American Federation of New York, 2003).

They also spend more time at leisure activities such as walking, physical exercise, shopping, and working at hobbies than other Asian ethnic minorities (Asian American Federation of New York, 2003).

Another small study assessing physical activity and functioning of elderly Filipino Americans (N=47) living in Oahu, Hawaii revealed that many subjects with multiple chronic diseases led sedentary lives and engaged less in physical exercise (Ceria, 2005).

Among the small groups of Filipino Americans who participated in seven ethnic-specific focus group surveys to determine perspectives on physical activity and exercise, most stated that exercise was perceived as important in counteracting the effects of high-fat diets in the US. They also agreed that physical activity and exercise aided digestion and circulation and made them feel strong, healthy, and energetic (Belza, 2004).

### Social Support

Compared to their Caucasian counterparts, multi-generational and multifamily households are common among Asians, including Filipino Americans. They are three times more likely to live in a household with spouse and other kin present, and are one-third less likely to be institutionalized (Himes, Hogan, & Eggebeen, 1996). Caring for elderly parents is taught and expected among children as part of their filial responsibility.

This practice is deeply embedded and integrated over time into their culture and passed on to the next generation (Mc Bride, 2006). Although acculturated families have become more accepting of the concept of institutionalization of their elderly relatives, they are still more reluctant to do so than the general population (Watari & Gatz, 2004).

“ [Filipino older adults] spend more time at leisure activities such as walking, physical exercise, shopping, and working at hobbies than other Asian ethnic minorities. ”

Traditional Asian families, including Filipino Americans, may be less likely to seek professional caregiver, respite, and supportive services, and consider it their responsibility to care for their elderly relatives.

### Health Care Disparities

Elderly Filipino Americans, like other ethnic minorities in the US, are not exempt from the disparities within the health care system. Data from the California Health Interview Survey showed that lack of health insurance is a major factor that prevents elderly Asian Americans, including Filipino Americans, from accessing mental health care. Less educated foreign-born older adults and those without US citizenship were more likely not to have health insurance (Mold, Fryer, & Thomas, 2004). Lack of mobility and poor English language proficiency are also two major barriers to health access (Trinh-Shevrin, 2009).

Health care access, utilization, and assimilation in the US health care delivery system can be very challenging for ethnic elderly minorities, including Filipinos, particularly for the newly arrived immigrants. In addition to financial constraints, lack of or minimal English proficiency and tenacious adherence to their own cultural and health beliefs can create a barrier to health care utilization. Immigrating to a new country can precipitate a stressful life event for the elderly. They tend to rely on their families for support since the majority of them are not eligible for government health care funds and social security benefits (Gorospe, 2006).

# CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

## Cohort Experiences

In order to provide appropriate and culturally sensitive medical care, health care providers should have insight about the historical background of Filipino Americans including their immigration history and discrimination experiences. This knowledge is key to understanding how elderly individuals and their family members respond to clinical encounters and recommended plans of care.

## Immigration History

### Early Period

In 1763, Filipino Americans established their first recorded North American settlement in St. Malo, Louisiana after escaping forced labor and enslavement during the Spanish galleon trade. Other settlements appeared throughout the Louisiana bayous with the Manila Village in Barataria Bay being the largest. From 1763 to 1906 other Filipino groups such as mariners, adventurers and domestics followed and eventually grew in numbers. With the passage of time some of them migrated to the West Coast, Hawaii, and Alaska to expand their opportunities in the fishing and whaling industries.

### After the Spanish-American War (1898)

The US colonization of the Philippines from 1900 to 1934 had a tremendous impact on Philippine immigration. Mass migrations began, as Filipinos became US nationals and were given the opportunity to live legally in the US under the protection of its law. Demand for labor on Hawaiian plantations and California farmlands attracted thousands of Filipino immigrants known as Sakadas (plantation workers) who came mostly from the provinces of Ilocos and Cebu to replace the Japanese work force who intended to leave the Hawaiian plantations. Although the Sakadas came to Hawaii as American Nationals, they

were not given full rights as American citizens and were the first Filipino Americans to experience racial discrimination and cultural oppression (Cordova, 1983). The Pensionados were a special group of privileged elite young men who came to the US in the early 1900s as government sponsored scholars.

The scholarship program was intended to educate these young men about the US government system, so that they would return to the Philippines to administer their own government in a similar fashion. After attaining their degrees most of them went back to the Philippines, but some remained in the US and blended in with the later Filipino immigrants known as Pinoys. Most of the Pinoys worked as farmers in California in the San Joaquin Valley, Salinas, and Sacramento. Some became factory workers in the Alaskan fishing and cannery industries, while others took low-paying custodian, busboy, and domestic service jobs.

The Pinoys had the most extensive experience with racial discrimination resulting from:

- changes in immigration policies
- anti-miscegenation laws (*see below*)
- and oppressive farm management practices

Many migrant families lived in poverty and children were forced to get educated, speak English only, and mainstream quickly.

### Anti-Miscegenation Laws

Also known as miscegenation laws, anti-miscegenation laws were laws that banned interracial marriage and, in some cases, sex between members of two different racial groups. These laws were enforced in the North American Thirteen Colonies from the late seventeenth century on. They continued to be enforced in several US states and territories until 1967 ([http://en.wikipedia.org/wiki/Anti-miscegenation\\_laws](http://en.wikipedia.org/wiki/Anti-miscegenation_laws)).

Some Filipino older adults and family caregivers may

**(FUND OF KNOWLEDGE CONT'D)**

have been part of this group (McBride, 2006; Tompar – Tui & Sustento-Seneriches, 1995; Yeo, 1998). In 1934 the US Federal law known as the Tydings-McDuffie Act was passed to limit Filipino migration to 50 persons per year. This law was later offset by the US Navy's recruitment of Filipino Americans who were exempt from such law.

**1935–1965**

During this period more Filipino women and families immigrated to the US. They were a combination of US military dependents (war brides), World War II veterans, professionals, and students. The Immigration and Nationality Act of 1965 permitted many Asian residents in the US, including Filipino Americans, to apply for citizenship. The law also gave those who had served honorably for three years in the US Armed Forces the opportunity to become eligible for naturalization. The law also allowed US citizens and permanent residents to sponsor family members to immigrate to join them in the US. Filipino Americans during this period experienced significant economic exploitation and social injustice despite their contributions to American society.

**1965–1990**

The Filipino American community became more diverse during this period due to the immigration of highly educated professionals, mostly in the health care field (i.e., nurses, doctors, and medical technologists). The 1965 Immigration and Nationality Act, which liberalized immigration laws, made it possible to sponsor other family members such as minor children, spouses, unmarried and married adult sons and daughters, and parents of adult US citizens. Similarly, a high proportion of international students were enrolled in American Universities (Cariño, 1996).

Some professionals who were not successful in obtaining professional licenses accepted lower status employment in the health field and in other areas. Some started small businesses. In the mid 1970s economic and political refugees from the Marcos regime and short-stay visitors (overseas contract workers, students, people in business, and tourists) added to the socio-cultural,

educational, economic, and political diversity of the community. Filipinos with short-term visas evolved into a labor pool for low paying or unpopular jobs such as nursing assistants, orderlies, or clerks in long-term care services (nursing homes, home care, live-in childcare or elderly caregivers). Some retired, professional older Filipinos who joined their families sought these types of employment or became surrogate parents for their pre-school and school-age grandchildren.

**1990 to the Present**

The 1990 amendment to the Immigration and Naturalization Act brought in an influx of aging WWII Veterans who were given instant American citizenship because of an unfulfilled promise to grant them US citizenship for fighting for the Allies in WWII.

Many of these veterans migrated to the West Coast and a large number live in California. They were allowed to immigrate but were not given service-related benefits. Without health benefits, they are accessing non-VA Services and a protracted advocacy for their welfare is an ongoing issue in the community. Aside from the WWII veterans, there was also a steady growth in the number of Filipino-born veterans engaged in active-duty military service during the Vietnam War, Korean War, and post-war era (Terrazas, 2008).

The number of Filipino immigrants dramatically increased, making them the second largest immigrant group in the US after Mexican immigrants. Many of the elderly Filipino immigrants who migrated to the U.S had less professional occupational backgrounds, and were thus less likely to find job opportunities in the American labor market. The jobs they do find are usually at minimum wage without benefits, or they are service-oriented jobs (such as baby sitting, care of the disabled or care of the elderly in the community) with private wage arrangements that don't require deductions for income taxes. These older adults are one of the minorities in the U.S that depend and rely on government assistance.

**(FUND OF KNOWLEDGE CONT'D)**

The family values of reunification, interdependence, social cohesiveness and collectivism continue to persist within the Filipino American community despite the existence of socio-economic and health care disparities and racism. The effects of acculturation on inter-generational Filipino families contribute to the heterogeneity within this population, particularly in its values, health beliefs, health practices, and attitudes toward health care and social services.

**Health Beliefs and Behaviors**

Different Asian cultures apply various models in perceiving and interpreting symptoms and illness. These models influence their decisions to seek medical treatment and services. A key principle shared by many Asian cultures is a holistic view of health, with an emphasis on balance and harmony between the individual's mind, body, and environment (Trinh-Shevrin, 2009). There is a considerable intra-cultural diversity among Filipino Americans with regards to health beliefs and health practices.

Filipino Americans who have been in the U.S for a long time are more acculturated to the American health system than those who recently migrated. The less acculturated immigrants adhere more to traditional systems of medicine and prefer indigenous healing practices, such as the use of complementary and alternative medicine.

Studies of health practices among Filipino Americans suggest that people originally from rural areas in the Philippines are more knowledgeable regarding home remedies, traditional healing techniques, and supernatural ailments, whereas those coming from the urban areas rely more on Western medical interventions and over-the-counter medications. However, healing practices in both groups are utilized simultaneously as well (Montepio, 1986/1987; Vance, 1999). Filipinos, especially those who migrated late in life, have the tendency to self-diagnose, self-medicate, and seek alternative therapies. This practice causes great concern to most health care providers, since these older adults

only seek medical care when their illness is already very serious or in an advanced stage, leading to missed opportunities for optimal treatment. Community-based efforts to promote equitable access to health care for Filipino American older adults through outreach using the support of Filipino American societies ( e.g. Knights of Columbus) will likely lead to earlier diagnosis and treatment.

**Indigenous Health Beliefs****Concept of Balance (Timbang)**

This concept is central to Filipino self-care practices and is applied to all social relationships and encounters. According to this principle, health is thought to be a result of balance, while illness due to humoral pathology and stress is usually the result of some imbalance. Rapid shifts from “hot” to “cold” cause illness and disorder. Illustrated below are a range of humoral balances that influence Filipino health perceptions:

- Rapid shifts from “hot” to “cold” lead to illness
- “Warm” environment is essential for maintaining optimal health
- Cold drinks or cooling foods should be avoided in the morning.
- An overheated body is vulnerable to disease; a heated body can get “shocked”
- When cooled quickly, it can cause illness
- A layer of fat maintains warmth, protecting the body's vital energy
- Imbalance from worry and overwork create stress and illness
- Emotional restraint is a key element in restoring balance
- A sense of balance imparts increased body awareness (Adapted from Becker, 2003).



**(FUND OF KNOWLEDGE CONT'D)****Theories of Illness**

Physical and mental health and illness are viewed holistically as an equilibrium model. In contrast, other explanatory models may include mystical, personalistic and naturalistic causes of illness or disease (Anderson, 1983; Tan, 1987; Tompar-Tiu & Sustento-Seneriches, 1995).

**Mystical Causes**

Mystical causes are often attributed to experiences or behaviors such as ancestral retribution for unfinished tasks or obligations. Some believe that the soul goes out from the body and wanders, a phenomenon known as *Bangungot*, or that having nightmares after a heavy meal may result in death.

**Personalistic Causes**

Personalistic causes are associated with social punishment or retribution from supernatural forces such as evil spirit, witch (*Manga ga mud*) or sorcerer (*mangkukulam*). The forces cast these spells on people if they are jealous or feel disliked. Witch doctors (*Herbularyo*) or priests are asked to counteract and cast out these evil forces through the use of prayers, incantations, medicinal herbs and plants.

For protection the healer may recommend using holy oils, or wearing religious objects, amulets or talismans (*anting anting*).

**Naturalistic Causes**

Naturalistic causes include a host of factors ranging from natural forces (thunder, lightning, drafts, etc.) to excessive stress, food and drug incompatibility, infection, or familial susceptibility.

**Basic Logic of Health and Illness**

The basic logic of health and illness consists of prevention (avoiding inappropriate behavior that leads to imbalance) and curing (restoring balance); it is a system oriented to moderation. Parallel to this holistic belief system is the understanding of modern medicine

with its own basic logic and principles for treating certain types of diseases. These two systems co-exist, and Filipino older adults use a dual system of health care (Anderson, 1983; Mc Bride, 2006; Miranda, Mc Bride & Spangler, 1999).

**Health Promotion/Treatment Concepts**

Health beliefs and practices are oriented towards protection of the body.

**Flushing**

The body is thought to be a vessel or container that collects and eliminates impurities through physiological processes such as sweating, vomiting, expelling gas, or having an appropriate volume of menstrual bleeding.

**Heating**

Adapts the concept of balanced between “hot” and “cold” to prevent occurrence of illness and disorders.

**Protection**

Safeguards the body’s boundaries from outside influences such as supernatural and natural forces.

**Health Behaviors****Response to illness**

Filipino older adults tend to cope with illness with the help of family and friends, and by faith in God. Complete cure or even the slightest improvement in a malady or illness is viewed as a miracle. Filipino families greatly influence patients’ decisions about health care. Patients subjugate personal needs and tend to go along with the demands of a more authoritative family figure in order to maintain group harmony. Before seeking professional help, Filipino older adults tend to manage their illnesses by self-monitoring of symptoms, ascertaining possible causes, determining the severity and threat to functional capacity, and considering the financial and emotional burden to the family.

They may even resort to utilizing traditional home remedies such as alternative or complimentary means

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of treatment. They may discuss their concern with a trusted family member, friend, spiritual counselor or healer (Yeo, 1998). Seeking medical advice from family members or friends who are health professionals is also a common practice among Filipino older adults and their family members, especially if severe somatic symptoms arise (Anderson, 1983).

**Coping Styles**

Coping styles common among elderly Filipino Americans in times of illness or crisis include:

- Patience and Endurance (*Tiyaga*): the ability to tolerate uncertain situations
- Flexibility (*Lakas ng Loob*): being respectful and honest with oneself
- Humor (*Tatawanan ang problema*): the capacity to laugh at oneself in times of adversity
- Fatalistic Resignation (*Bahala Na*): the view that illness and suffering are the unavoidable and predestined will of God, in which the patient, family members and even the physician should not interfere
- Conceding to the wishes of the collective (*Pakikisama*) to maintain group harmony

**Responses to Mental Illness**

Indigenous traits common among elderly Filipino Americans when faced with illness related to mental conditions:

- Devastating shame (*Hiya*)
- Sensitivity to criticism (*Amor Propio*)

“ Seeking medical advice from family members or friends who are health professionals is also a common practice among Filipino older adults and their family members, especially if severe somatic symptoms arise. ”

**Common Perceptions of Filipinos about Mental Illness**

- Unwillingness to accept having mental illness, which leads to the avoidance of needed mental health services due to fear of being ridiculed
- Involvement of other coping resources such as reliance on family and friends or indigenous healers, and dependence on religion which can diminish the need for mental health services
- Prioritizing of financial and environmental needs which preclude the need for mental health services
- Limited awareness of mental health services resulting in limiting access
- Difficulty in utilizing mental health services during usual hours because of the unavailability of working adult family members
- Mental illness connotes a weak spirit, and may be attributed to divine retribution as a consequence of personal and ancestral transgression
- Lack of culturally oriented mental health services

Though such coping mechanisms, perceptions and traits may help elderly Filipino Americans adjust initially to their illnesses, these tactics also pose barriers and impede implementation of necessary treatment intervention in a timely fashion.

**Health Promotion and Disease Prevention**

There is a scarcity of research on screening practices among elderly Filipino Americans, and only a few studies have been done among aggregates of different Asian ethnic backgrounds. Although many Filipino older adults with minimal acculturation might be familiar with the common health screening programs, the importance of such screening to their health status may be poorly understood. Adult family members may facilitate, delay, or block older adults' access to screening services as a means of protecting them from external forces (Mc Bride, 2006; Miranda, 1999; Soison & Antes, 1988). On the other hand, Filipino Americans with

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extensive acculturation experience may be more able to make use of the screening services that place significance on maintaining good health (Maxwell, 2000; McBride, 1997; McBride, 1998).

A Los Angeles study of Filipino American women's (50 years and older, N=218) attitudes towards breast screening practices revealed lower screening rates among women who had shorter lengths of stay in the U.S (<10 years), less acculturation experience, and a lower level of education.

Concrete barriers, such as cost and time, and attitudinal variables, such as fear of finding breast cancer and the perception that mammograms are only necessary if symptoms are present, also influence screening practices (Maxwell, 1997).

Disparities in colorectal cancer screening also exist among Filipino Americans. A Los Angeles study in 2005-2006 (50 to 75 years old, N=487) revealed that less acculturated and lower income Filipino Americans received fecal occult blood screening (FOBT) without endoscopy, while Filipino Americans with a higher income and more extensive acculturation underwent endoscopy (colonoscopy) with or without FOBT. This disparity persists after adjusting for access to care (Maxwell, 2008).

A 2001 California Health Interview Survey, which examined colorectal cancer screening (CRC) rates among different Asian ethnic minorities (N=1771) 50 years of age and older, showed that Filipinos were the least likely to undergo CRC screening or to be up to date with screening, especially if they were older, male, less educated, recent immigrants, living with 3 or more other individuals, or poor and uninsured (Wong, 2005).

## Cultural Values

### Interpersonal Relationships

Smooth Interpersonal Relationships are a core value for every Filipino community; they involve a shared identity, engagement on an equal basis with others, and giving importance to the individual versus agencies or

“ A Los Angeles study of Filipino American women's (50 years and older, N=218) attitudes towards breast screening practices revealed lower screening rates among women who had shorter lengths of stay in the U.S (<10 years), less acculturation experience, and a lower level of education. ”

institutions. This cultural characteristic is also known as “Personalism.” The high value placed on sensitivity and regard for others, respect and concern, understanding, helping out, and consideration for others' limitations, often creates discord with American tendencies toward openness and frankness (Agoncillo & Guerrero, 1987; Enriquez, 1994).

Perceptions regarding physician preferences dictate who will provide care and how much trust is given.

### Two main concepts determine the interaction between a Filipino and a health care provider:

1. “One of Us” (*Hindi ibang Tao*) versus
2. “Not one of Us” (*Ibang Tao*)

Health providers who are respectful, amenable and willing to accommodate the patient's needs are considered to be *Hindi ibang Tao*.

If the provider is considered *Ibang Tao*, Filipino Americans will be reluctant to express their feelings and emotions. They will designate a family member to mediate or advocate on their behalf while responding politely to the provider at a formal and superficial level.

**(FUND OF KNOWLEDGE CONT'D)****The concept “Not one of Us” involves:**

- civility (Pakikitungo)
- mixing (Pakikisalamuha)
- joining/participating (Pakikilahok)
- adjusting (Pakikisama)

**The concept “One of Us” includes:**

- mutual trust/rapport (Pakikipagpalagayan ng loob)
- getting involved (Pakikisangkot)
- oneness/full trust (Pakiisa)

(Pasco, 2004; Enriquez, 1994; Pe Pua, 1990).

**Family and Filial Responsibility**

Children are taught to show affection for older family members and respect for older adults and authority. They are expected to seek the advice of and accept the decisions of their older adults. They are obligated to care for older adults and aging parents, and maintain group harmony, loyalty, and emotional ties with parents and other family members across the life span (Chao & Tseng, 2002; Mc Bride, 2006; Miranda, Mc Bride & Anderson, 2000; Superio, 1993). In a study of Asian American older adults in New York City, Filipino older adults (N=52) were the least likely to consider care giving responsibility a burden and dependency on other people a serious problem (Asian American Federation of New York, 2003).

**Spiritual Life and Religiosity**

Religion is deeply embedded in and intertwined with Filipino culture. It is central to people's lives and enables them to face life's challenges and adversities with strength and optimism (Tompar-Tiu & Sustento-Seneriches, 1995). Filipino Americans use spirituality and religion as part of their coping practice, especially when dealing with illness.

**Religious practices include:**

- attending mass
- praying the rosary and novena
- expressing devotion to saints and the Virgin Mother
- receiving the sacraments and holy communion
- reconciliation
- anointing the sick
- observing religious holidays and rituals
- going on pilgrimages

In a small qualitative research study of elderly female Filipino immigrants in Vallejo, CA, most of the participants believed that certain illnesses that cannot be treated by modern medicine can be treated through divine intercession (Verder-Aliga, 2007). Prayers, church affiliation, spiritual fellowship and counseling play a crucial part in the healing process and in the promotion of wellness and good health.

In a study on culture and health among Filipino Americans in central Los Angeles, the majority of elderly Filipino subjects exhibited deep levels of religiosity, and had a strong view of God's role in human health and wellbeing (Historic Filipinotown Health Network, 2007).



# CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

## Preparatory Considerations

### Demonstrating Respect

Use Miss, Mrs., or Mr. when addressing an elderly Filipino American. Avoid addressing the elder by first name during the first encounter since this familiarity might be perceived as a sign of disrespect.

### Greeting

A firm handshake with a smile and eye contact is appropriate. If the older patient is accompanied by other family members, greet the older patient first. The social greeting “*How are you?*” translates into Tagalog as “*Kumusta po kayo*”. The word *po*, which conveys respect, is automatically added at the end of every sentence or phrase when communicating with an older or elderly person.

### Informal Conversation

Having a conversation about grandchildren or other non-medical life events or interests (hobbies) puts the Filipino elder at ease. A clinician who shares briefly a personal anecdote, particularly about children in her/his family, is recognized more as human being to whom the older adult can relate rather than as an authority figure.

## Communication Issues

### Verbal Communication

#### 1. English Proficiency

Many Filipinos take pride in their ability to read, write, and speak English. They may feel offended if asked about the need for an interpreter.

#### 2. Culture-Based Communication Guide

Though many elderly Filipino Americans can communicate in English, there may be challenges when they are confronted with high-stress situations.

### For clinicians working with older Filipino individuals, the following guidelines may be useful:

- When the cadence and inflections in spoken English make it difficult to understand the patient, ask permission to seek the services of an interpreter. To avoid offending the patient, explain that the purpose of having the interpreter is to reassure the clinician that the medical terms are accurately described to the patient.
- It is important not to use family members/friends as interpreters for health care related issues.
- When introducing the need for an interpreter, do so in a respectful manner as in the following model presentation:

*“Mrs. Kabayan, I want to discuss some important issues related to your health. I know that you speak English. However, with your permission, I would like to request the presence of an interpreter today. An interpreter will help both of us communicate clearly with each other, I do not mean any disrespect. I just want to make sure that we give you the best possible care and using an interpreter will help ensure this.”*

- Questions such as “*Do you understand?*” or “*Do you follow?*” may be considered disrespectful. Instead, ask the patient to repeat the instructions with the explanation that the feedback process is for the clinician’s benefit to ascertain whether he/she has done a thorough job.
- For elderly Filipino Americans who are less educated and have minimal acculturation experience, never make the assumption that a “Yes” answer means that she or he understood the discussion or agrees with the decision or opinion of the health care provider. In most cases, “Yes” merely means “I heard you.” Filipino older adults who are used to high-context communication may feel puzzled and offended by the preferred precision and exactness of the American communication process.

**(ASSESSMENT CONT'D)**

- Many older adults, particularly those from intergenerational households, look to a trusted adult family member as their “surrogate decision maker” and would expect the clinician to keep this individual informed of issues related to their health. Such a preference may not be expressed or openly discussed by the elder or the family member.
- It is considered disrespectful to challenge, question, or express disagreement with an authority figure such as a health care provider. To encourage open communication, providers need to reassure a reticent or passive elder that asking questions or expressing opinions would not offend them.
- Use phrases that connote relationships such as “*Our aim is,*” “*This is your problem*” and “*We are working on this.*”
- Clinicians should explore and listen to older adults’ beliefs about health and illness. Be respectful of their behaviors. Patiently explain from your perspective what has to be done and why.
- When an older adult is accompanied by other family members, seek the elder’s consent before disclosing sensitive and private issues in order to maintain the patient’s privacy and autonomy and avoid embarrassing the patient.

### Common Words or Phrases Used in Communicating with Elderly Filipino Immigrants (English to Tagalog)

- Good Morning: *Magandang Umaga Po*
- Good Afternoon: *Magandang Hapon Po*
- How are you?: *Kumusta po kayo?*
- What can I do for you?: *Ano po ang may ipaglilingkod ko?*
- Thank you: *Salamat po*
- You are welcome: *Wala pong anuman*
- Yes: *Opo/Oho*
- No: *Hindi po/Hindi ho*

Please double-click to hear audio ➡



## Non-Verbal Communication

### 1. Pace of Conversation

Allow brief periods of silence or pauses in the conversation to enable the patient to process information that may be occurring in the native language (Tagalog), especially for those with limited English proficiency.

### 2. Physical Distance

Maintain a reasonable personal space of 1 to 2 feet. Take height into consideration. A seated position for interaction is highly recommended.

### 3. Eye Contact

Sit at eye level with the patient for the interview; make brief and frequent eye contact, even though the patient’s eye contact is of shorter duration than the clinician’s. Older patients may look down or look away most of the time as a sign of respect to an authority figure, a professional, or someone who is of a higher social class. Prolonged eye contact between an older Filipino male patient and a younger female clinician may be flirtatious.

### 4. Emotional Responsiveness

Filipino Americans’ emotional responsiveness and affect may be misleading. Look for changes in facial expression—older adults may smile or chuckle inappropriately, which could be a sign of nervousness or embarrassment or may be simply a personal mannerism. Explore the meaning of flat affect and downcast eyes during the interview.

## (ASSESSMENT CONT'D)

**5. Body Movement**

Frequent hand gestures may be used by Filipino Americans for emphasis:

- They may cover their mouths with one hand when making conversation or smiling as an expression of shyness or embarrassment.
- The common American gesture for “come here”, i.e., moving the pointed upward index finger forward and back, is an insulting gesture to less acculturated Filipino Americans. An acceptable gesture is to extend one hand towards the person with palm facing down and then flex and extend the four fingers (with no thumb) several times.
- Head wagging or nodding (unconscious movement of one’s head) has many meanings and should not be confused with shaking one’s head in agreement.
- Head movement can also mean “*Yes I’ll cooperate*” or “*I hear you*” even though the person does not understand you. This is mostly the case among Filipino immigrants who are less educated and have minimal acculturation experience.

**6. Touch**

Young female service providers should practice discretion when touching older Filipino male patients in situations such as laying a hand on the patient’s hand or shoulder to give comfort in moments of distress. Elderly Filipino women have a heightened sense of modesty, and show reservation in subjecting themselves to physical examinations involving female body parts. Health care providers should ask permission before performing this kind of examination and should avoid rushing through the procedure.

A male provider should always be accompanied by a female staff member when examining an elderly female’s private areas. Elderly Filipino women may spontaneously touch a hand or arm or hug a service provider to express appreciation for services rendered.

**Use of Standardized Assessment Instruments**

Except for A Short Acculturation Scale for Filipino Americans (ASASFA), to date there are no known geriatric assessment instruments that have been validated and standardized for Filipino Americans. The ASASFA was designed for bilingual Filipino immigrants receiving healthcare at Southern California health maintenance organizations, the majority (77%) of whom had college and/or advanced education (de la Cruz, Padilla, & Butts, 1998).

**Ethnogeriatric Assessment****Ethnic Affiliation and Acculturation****Community Involvement**

Assess participation in social, cultural, and educational activities in the Filipino community. Active membership in local Filipino organizations may indicate the extent of the support network in the community. One might want to:

- Assess for indigenous tribal ancestry—e.g., Muslim, Negrito, Malayan, Mestizo, or
- Assess for multi-racial background— Filipino Americans have the second largest number of interracial marriages among Asian immigrant groups (Le, 2010).

**Language Assessment**

Determine language preferences for interviews and written health information. **Two of the items in the five-point Likert Scale have proven to be significant predictors of acculturation:**

1. Language preference
2. Self-identification of cultural identity (e.g., self-identification of cultural identity as very Filipino, somewhat Filipino, partly Filipino, partly American, mostly American, very American).

**(ASSESSMENT CONT'D)****Religion**

Assess how the elder practiced his or her religion prior to immigrating to the US as well as the current religious practice. Determine the importance of religious affiliations, activities, rituals, and other support from the church that help promote and maintain the patient's spiritual growth and stability.

**Patterns of Decision-Making**

Filipino culture fosters values that enhance group harmony and smooth interpersonal relationships. Family cohesiveness serves as a driving force for shared decision making among family members in accordance with the patient's needs. Clinicians could develop a family decision-making tree or algorithm.

A primary decision maker may not be designated prior to a health crisis. Decisions may be delegated to family members living outside the US, or birth order may be used to designate the decision maker (McBride, 2006; Tompar – Tiu & Sustento – Seneriches, 1995).

**The clinician should ask questions such as:** *“Who should we talk to?” or “Who can help in making decisions about your treatment in the future?”* Family members are often expected to make decisions or speak for older adults; those without any close relatives may rely on friends, clergy, or a trusted service provider.

In complicated situations, a “go-between,” such as a trusted friend (*compadre/comadre*), cleric or member of a faith organization, who is usually not a family member, may facilitate the interaction or dialogue.

**Clinical Assessment Domains****Health and Social History****Mental Health**

Risk factors for depression among elderly Asian American women, including Filipino immigrants, include:

- poor general health with increased impairment of activities of daily living (ADLs)
- social isolation
- stressful life changes
- requiring a higher level of assistance from children
- being less religious
- experiencing a greater cultural gap between themselves and their children. (Asian American Federation of New York, 2003)

The care giving or surrogate-parenting role can also place a burden on elderly individuals, which could result in situational depression (McBride 2006; Tompar – Tiu & Sustento – Seneriches, 1995).

Clinicians should be cognizant about common indigenous traits and perceptions among elderly Filipino Americans suffering from mental illnesses such as depression.

**Several validated screening tests can be utilized to facilitate the detection of depression in elderly adults, including:**

- Center for Epidemiologic Study Depression Scale
- Geriatric Depression Scale
- General Health Questionnaire
- Beck Depression Inventory



**(ASSESSMENT CONT'D)****Recommendations**

- Pay attention to the level of education and acculturation and English language proficiency. Always ask for professional interpreters when administering such screening tests.
- Assess for social support and availability of other community resources.

**Risk of Elder Abuse**

Risk factors for abuse may include:

- lower levels of acculturation,
- living with non-family members or in an inter-generational household
- dependence on other adults to move about
- lack of ability to use simple technology (e.g. telephone),
- lack of English proficiency
- degraded physical appearance (i.e., self neglect) (Lewis, Sullivan & McBride, 2000).

**“ Traditional treatment (herbals, nutritional supplements, prayers, etc.) often are used concurrently along with Western medical treatment (Grudzen & McBride, 2001; McBride, 2006). Thus, we stress the importance of eliciting the usage of indigenous healing practices in a gentle and non-judgmental manner and take time to educate patients and families about the potential for adverse interactions between the different systems of healing. ”**

Also assess for other suspicious physical signs of abuse, and for other types of abuse (emotional abuse, sexual abuse, neglect by caregivers, self-neglect, financial exploitation, and health care fraud and abuse).

**Use of Community-Based Healers and Spiritual Counselors**

Traditional treatment (herbals, nutritional supplements, prayers, etc.) often are used concurrently along with Western medical treatment (Grudzen & McBride, 2001; McBride, 2006). Thus, we stress the importance of eliciting the usage of indigenous healing practices in a gentle and non-judgmental manner and take time to educate patients and families about the potential for adverse interactions between the different systems of healing.

**Other Sources of Health Care**

Older adults who frequently travel to the Philippines or visit other family members in the US may be receiving medical care from a physician in the Philippines or in other locations.

**Dietary History**

The Filipino American diet is relatively high in fat and cholesterol compared to the diets of other Asian Americans. Organ meats such as tripe, pork blood, pork and chicken intestines, and poultry liver are well-liked. The typical diet uses high-sodium condiments such as fish sauce (Patis), shrimp paste (Bagoong), soy sauce (Toyo), anchovies and anchovy paste. Pastries and rice cakes high in concentrated sugar are often eaten for dessert.

Due to these dietary practices, Filipino Americans are at high risk for developing cardiovascular-related conditions (coronary artery disease, hypertension, hyperlipidemia, obesity, diabetes, hyperuricemia and gout). Filipino Americans exhibit significantly higher levels of hypertension than other Asian Americans. These levels are similar to those in African Americans who live in the US (Nguyen, 2006).

**(ASSESSMENT CONT'D)****Physical Examination and Screening Test****Respiratory Diseases**

COPD and respiratory infections such as influenza and pneumonia rank 4th and 6th as the leading cause of death respectively among elderly Filipino Americans. Increased incidence of smoking among Filipino men compared to other Asian ethnic groups put them at higher risk for developing COPD. Increasing age, presence of other chronic co-morbidities like diabetes mellitus, cardiovascular disease such as CHF, and COPD put them at higher risk for developing pneumonia and influenza. Identify personal risk factors, medical history, social habits, and immunization history.

**Cognitive and Affective Status**

Stigma and shame may delay access to diagnostic and treatment resources for Alzheimer's disease and mental health problems. It is common for less-educated elderly Filipino immigrants with minimal acculturation experience to perceive such cognitive problems as part of the normal aging process. Highly acculturated families may be hesitant to seek resources. The public image of the family is the prime concern, and there is a tendency to be crisis-oriented.

Psychiatry is perceived to be a resource for the affluent. Somatic symptoms such as headache, loss of appetite, sleeplessness, fatigue and low energy level are common presentations of depression. Medication for treating mental illness is much preferred to psychotherapy. Trusted members in the community such as clergy, lay ministers or healers may be preferred. Family therapy or group therapy may be too threatening to less acculturated older adults.

In evaluating elderly Filipino patients for cognitive dysfunction and mental illness, one should be cognizant of common indigenous traits, perceptions, and coping mechanisms. Simple validated screening tests such as the Geriatric Depression Scale (GDS) for depression, the Mini Cog and the Clock Drawing Test to determine cognitive dysfunction are easy to administer, especially among less educated and less acculturated elderly

“ A sense of social isolation may be interpreted by older adults as rejection by the family, lack of respect, lack of love and being unwanted. These assumptions evoke feelings of psychological neglect. ”

individuals. For highly educated individuals, more sensitive (98%) and specific (97%) tests such as the Mini Mental State Exam, the Clock Drawing Test and the Mattis Dementia Rating Scale are preferable.

**Osteoporosis Screening**

Despite limited research concerning the risk and incidence of osteoporosis among elderly Filipino Americans, this group is not immune and is at increased risk with advancing age. Initial screening using the DEXA Scan should begin at age 65 for women with a low risk of developing osteoporosis or fracture. Initial screening using the DEXA Scan should begin between the ages of 60 – 64 for women with a high risk of developing osteoporosis or fracture. Repeat screening every 2 years using the DEXA Scan. In addition to physicians, nurses in the ambulatory care setting play an important role in educating patients and families about this issue.

**Cardiac and Vascular Diseases**

Cardiovascular disease, stroke, diabetes mellitus, aortic aneurysm and dissection and hypertension rank respectively as numbers 1, 3, 5, 9 and 10 among the leading causes of death for elderly Filipino Americans. These risks are amplified by increasing age, unhealthy social habits (smoking) and dietary practices and physical inactivity.

**Cancer**

Malignancy ranks second as the leading cause of death for elderly Filipino Americans. Decisions to screen patients should be individualized and be based on

**(ASSESSMENT CONT'D)**

the following factors such as expected life expectancy, preferences, plan for what the patient may or may not want to do further if screening had positive findings, as well as degree of burden to the patient (Hall KT, 2010).

**Functional Status**

Assess patient activities in the community, the presence or absence of activities of daily living (ADL) impairments, and environmental home safety measures. Because of the cultural value of interdependent/dependent relationships, determining the presence or absence of instrumental activities of daily living (IADL) impairments (driving skills, using and balancing check books, use of modern household appliances) may not be critical for less acculturated and low income elderly individuals who depend heavily on other family members.

**Family and Community Assessment**

Older adults could be living in a group setting with unrelated adults, in an extended family, with a spouse, or alone. The Filipino community monitors this subgroup through organizations. Highly acculturated older adults (who age in place) may be isolated from the Filipino community. An extended Filipino family may include non-biological members. Integration into the family system occurs slowly as individuals become known and trusted.

Within the Filipino community, children are taught filial responsibility and respect for older adults. A lack of support may be perceived when adult children have two or more jobs. A sense of social isolation may be interpreted by older adults as rejection by the family, lack of respect, lack of love and being unwanted. These assumptions evoke feelings of psychological neglect. Depending on resources, older adults may take periodic trips to the Philippines or visit adult children in various parts of the US. Older adults also make telephone calls and exchange videotapes in order to communicate with relatives and friends living outside the US.

**Important Characteristics of Neighborhoods**

Characteristics of urban or suburban neighborhoods that might be important to Filipino American older adults include:

- availability of public transportation
- presence of Asian businesses
- Asian or Filipino food products in the grocery stores
- proximity to a senior center
- nearby church and recreational facilities
- degree of integration of the neighborhood
- size of the Filipino American population
- crime rate
- air quality
- recreational facilities that offer activities and services popular with Filipino seniors such as dancing, picnics/barbeques, popularity contests followed by award and dinner/dances
- support from the neighborhood and community in the form of programs such as neighborhood watch.

Suburban living without these features, or living in an inter-racial household, may produce a sense of social and cultural isolation.

# CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

## End-of Life Preferences

Few studies have systematically examined the cultural needs of Asian ethnic minorities regarding end-of-life care. Filipino families may struggle with or avoid talking about advance directives and life support decisions when family members are seriously ill or dying. Culture and beliefs also dictate the rules for disclosure or truth-telling regarding terminal health diagnoses and prognoses. Filial obligation is imperative in the Filipino culture and is practiced to protect the patient, maintain hope, and ensure a good death. Discussions regarding end-of-life issues and advance directives should be approached cautiously, because discussing such sensitive issues may raise the fear that the discussion itself could lead to or invoke unwanted outcomes (Cantos, 1996).

Many Filipinos have fatalistic perceptions known as “Bahala Na” (what is destined or inevitable; illness is always “the will of God”) when confronted with serious or life-threatening illness (Mc Laughlin, 1998; Bigby, 2003; Vance, 1995). A descriptive, correlational, cross-sectional study of 22 critically-ill Filipino Americans, aged 55 and older, and their family members regarding attitudes towards advance directives showed that overall attitudes towards advance directives were positive, especially among acculturated and highly educated families. Completion rates among the patients were low (10%), most probably due to their fatalistic belief that illness is destined or inevitable, thus rendering advance directives pointless (Mc Adam, 2005).

A large retrospective study was conducted of the last year of life of Asian-American Pacific Islander (AAPI) and white Medicare beneficiaries registered in the Surveillance, Epidemiology, and End Results Program. White (n=175,467) and AAPI (n=8,614) patients aged 65 and older who were dying with lung, colorectal, breast, prostate, gastric, or liver cancer were studied (Ngo-Metzger, Phillips & McCarthy, 2008).

The data showed that all Asian Americans including Filipino American older adults were less likely to enroll in hospice care. In a Filipino American and Cambodian American comparative study which involved three in-depth interviews over a 1-year period with 48 Cambodian Americans and 78 Filipino Americans, the subjects stated that they wanted to go back to their country of origin and die in their homelands (Becker, 2002).

## Problem-Specific Data

Different models can be applied in providing culturally responsive care to Filipino Americans.

Panos and Panos (2000) developed a culturally sensitive assessment process that focuses on several domains:

- Physician awareness of his or her own cultural identity
- Identification of patient’s cultural orientation, belief system, level of acculturation and language preference
- Assessing patient’s stress and adaptive coping and functioning
- Determining patient’s family relationships and support system
- Assessing patient’s views on and concepts of health and illness



## INSTRUCTIONAL STRATEGIES: CASE STUDIES

### Case Study 1

Mr. Bautista is a 67-year-old Filipino male immigrant who has lived in the U.S. for the last 35 years. He was recently diagnosed with metastatic pancreatic cancer. During a comprehensive end-of-life care discussion with the oncologist, he was given a prognosis of less than 6 months to live, and was advised to transition to hospice. Despite the doctor's recommendation, the patient expressed a strong desire to seek a second opinion, and was not completely convinced about the terminality of his condition.

Mr. Bautista is highly optimistic and has not lost hope for a cure. Because of his strong religious beliefs that he is just being tested by God and miracles can happen, he and his spouse find it difficult to shift their hopes from cure to comfort care. A second opinion from another healthcare provider confirmed Mr. Bautista's poor prognosis, though participation in a clinical trial was also encouraged. After discussing the trial's burdens and benefits with the doctor, Mr. Bautista made a quick desperate decision to participate in the trial without any reservations with the hope that his life would be prolonged or that he would even achieve a complete cure.



#### Discussion Questions

1. When Filipinos are faced with serious illness, how do their cultural views and behaviors affect their response to illness and influence their decision-making in negotiating between different therapeutic options regarding end-of-life care?
2. Explore what the patient's beliefs mean in the context of his underlying condition.

## (INSTRUCTIONAL STRATEGIES: CASE STUDIES CONT'D)

**Case Study 2**

Mr. Alvarez is a 72-year-old Filipino male who was previously healthy with no chronic medical conditions, when he was suddenly admitted to the hospital subsequent to a stroke with left-sided weakness and dysphagia. Even though he spoke and understood minimal English prior to this admission, he has been having difficulty expressing himself and communicating with the nursing staff members, and easily gets frustrated whenever his requests and physical needs are not adequately met.

His hospital course was complicated by aspiration pneumonia and hypotension leading to end organ failure and sepsis, necessitating pressors, broad spectrum antibiotics and ventilatory support. While in the ICU, he coded, was resuscitated and eventually revived 15 minutes later, although this event left him with anoxic brain injury. Mr. Alvarez is a full code. He does not have any advanced directives in place, nor has he appointed his power of attorney for healthcare. He has not in the past expressed his wishes or communicated with his wife and children about his care preferences for this particular situation.

Due to the grim prognosis, the intensivist met and discussed with the family members the patient's declining condition and poor quality of life while being kept alive on the ventilator, emphasizing that there was no chance of survival. The intensivist therefore recommended withdrawing life support.

The patient's spouse, being the next of kin with the authority to decide on behalf of Mr. Alvarez, was very tearful and upset and was having difficulty processing the information given. She sought the advice of his children, and a family consensus was made to continue aggressive management. Their decision was based on several strong religious and cultural beliefs such as: "As long as there is faith there is hope", "Miracles could happen", "It is in the hands of God now", and "God is the only one who can decide whether the patient will survive or not".

As a healthcare provider, you feel strongly that this is an act of medical futility, and you are perplexed with the family's decision to continue aggressive management in order to prolong the patient's life despite his poor chance of survival.

**Discussion Questions**

- 1** As the healthcare provider, how will you be able to advocate for the patient and his family without undermining their cultural beliefs regarding end-of-life care?
- 2** Enumerate some strategies that can be implemented by the healthcare provider in order to achieve meaningful and culturally appropriate goals for the patient and family members.

## (INSTRUCTIONAL STRATEGIES: CASE STUDIES CONT'D)

**Case Study 3**

Mrs. Romero, an 85-year-old widowed Filipino female who still has the capacity to make her own decisions, was accompanied by her daughter for a follow-up visit. A few days earlier, the daughter had received a message from the doctor's office regarding Mrs. Romero's bronchoscopy results and was advised to return to the office with her mother as soon as possible. The purpose of this appointment was to discuss the test results and plan of care. The physician approached the daughter before meeting with the patient, and told her about the results, which were positive for metastatic non-small-cell cancer non-responsive to any treatment.

After learning this, the daughter requested that the physician not disclose the results to her mother in order to protect the older woman, prevent despair, and maintain hope. The daughter maintained that her mother had a delicate emotionally-labile personality and would be unable to handle such sensitive information. Mrs. Romero would definitely be devastated and might become severely depressed. The daughter, having understood that there was no treatment option available to prolong her mother's life, decided to take her mother home with hospice.

As the healthcare provider, you are not quite sure what to do. You feel very uncomfortable not sharing such information with the patient, whom you feel has the right to know, and yet the daughter is adamant that you not tell her mother the diagnosis.

**Discussion Questions**

1. How can cultural beliefs and practices influence rules for disclosing or truth-telling regarding terminal health diagnoses?
2. List some interventions that could foster and improve communication between the healthcare provider and the family members when dealing with requests for non-disclosure of serious health conditions to the patient.

## (INSTRUCTIONAL STRATEGIES: CASE STUDIES CONT'D)

**Case Study 4**

Mrs. Evangelista is a 92-year-old cachectic frail-looking Filipino female who was diagnosed with dementia 7 years ago. Her oral intake has decreased over the past 6 months and she has occasional choking spells when being fed. She has lost a significant amount of weight (20 lb.) over the past year despite complete nursing care provided at home by her 2 unmarried daughters, who are now in their 60's. She spends most of her time sitting in a chair or lying in bed, is dependent in all of her activities of daily living (ADL's), and had falling incidents twice in the past year. She cannot carry on an intelligible conversation and can only express herself by uttering a few incomprehensible words and by using non-verbal gestures. She is incontinent with bowel and bladder function, and has developed multiple small stage 2 pressure ulcers in her buttocks.

When the health care provider made a home visit, one of the daughters expressed concern regarding her mother's progressive weight loss due to feeding difficulties, and requested that a PEG tube be inserted. Through her knowledge of other people's experience she believed that this intervention would improve the patient's nutritional status. The health care provider maintained that it was not an appropriate intervention for this setting and explained the risks and benefits of the procedure to the family member. The daughter was not quite satisfied or convinced, and continued to insist on having it placed.

**Discussion Questions**

1. What cultural values and beliefs could explain the family member's behavior and her concern regarding the patient's declining condition?
2. As the healthcare provider, how can you develop the trust of the family members, and be able to formulate culturally meaningful and appropriate patient-centered goals that would be acceptable to family members as well?

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