

HEALTH AND HEALTH CARE OF FILIPINO AMERICAN ELDERS

Melen McBride, RN, PhD

Stanford Geriatric Education Center

Stanford University School of Medicine, Stanford, California

DESCRIPTION

This module reviews the available information on demographic and cultural characteristics, the historical background, health beliefs, and health risks of elders from Filipino backgrounds in the U.S. Recommendations for health interventions are also included. The module is designed to be used in conjunction with the Core Curriculum in Ethnogeriatrics.

LEARNING OBJECTIVE

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

1. Describe major sociodemographic characteristics of the Filipino American community and their elderly.
2. Identify significant historical and sociopolitical events that influenced the immigration of Filipino elders to the U.S.
3. Identify at least five cultural factors that affect the interaction of older Filipinos with the health care system.
4. Discuss the major sources of health data, gaps in information, mortality and morbidity rates, and health problems for older Filipino Americans.
6. List major conditions that are different for subgroups of Filipino elders.
7. Describe living arrangements and patterns of social support for frail and disabled older Filipino Americans.
8. Identify at least five critical areas for health assessment, screening, and intervention.
9. List at least five culturally acceptable approaches that could facilitate communication and trust building between a less acculturated elder and a service provider.

CONTENT OUTLINE

I. Introduction and Overview

A. Demographics

Filipino Americans now rank as the second largest Asian group in the United States with over 1.8 million individuals reported in the 2000 census. The subgroup of age 65 and over is just slightly smaller than Chinese American elders. Average per capita income is slightly below the national average, and 75% of Filipino households have pooled income from 3 or more adults working. Many of these households are intergenerational where grandparents become surrogate parents for young families.

Characteristics of Filipino Americans aged 65 and over in 1990 were (Young & Gu, 1995):

- 95 % were born outside the U.S.; 57% were naturalized;
- 89% spoke a language other than English; 56% said they do not speak English very well; 17% are classified as linguistically isolated;
- 43% had less than 9th grade education; 16% had undergraduate or advanced degrees;
- 18% were still employed;
- 8% lived in poverty;
- 30% of those 75 and older lived alone.

B. Language and Culture

In Philippine society, Pilipino or Tagalog is the national language, and English is the second official language. While about 80-100 ethnic languages are spoken in this country of 7000 islands, there are eight major mutually unintelligible regional languages spoken - Pilipino/Tagalog (29.6%), Cebuano (24.2%), Ilocano (10.3%), Ilonggo (9.2%), Bicolano (3.5%), Waray (4%), Kapampangan (2.8%), and Pangasinanes (<1%) (Lamzon, 1978; Enriquez, 1994; Tompar-Tiu and Sustento-Seneriches, 1994). English is used to conduct internal and global business. Among Filipino Americans, a combination of English/Tagalog or "Tag-Lish" a hybrid language, is spoken by many and is used extensively in the Filipino American media, visual and performing arts, and marketing campaigns. More than two-thirds of households speak a non-English language. Even though many elders speak English, there is strong preference to speak their own native language particularly in high stress situations.

An estimated 80% of Filipinos are Catholics; some are members of Protestant churches, and others the Aglipay, a church whose origin is in the Philippines. Filipino Muslims originate primarily from Mindanao and Sulu - the southernmost region of the country where successful resistance to Spanish colonialization led to preservation of their culture

and traditions. Collectively, the sociocultural, psychological, economic, and political legacy of the pre-colonial Filipino tribes were congruent with those of Islander people in the Pacific rim.

The Filipino values of interdependence and social cohesiveness may have evolved from the group orientation necessary to live in an archipelago of 7000+ islands, located in the ring of fire, where only 1000 islands are habitable. This may partly explain the existence of hundreds of Filipino American organizations across the U.S.

II. Patterns of Health Risk

A. Health Status: Morbidity and Mortality

A dearth of scientific data on older Filipino Americans exists primarily because health data on Asians are difficult to disaggregate, because of the inconsistencies in coding race and ethnicity in research projects (Yoon & Chien, 1996), and because only a handful of researchers are focusing their research on Filipinos. Despite recent growth in the population, no national studies have been conducted in this population similar to the Hispanic HANES study. The health information on Filipino American elders summarized below was compiled primarily from small research reports in individual communities (McBride, Morioka-Douglas, & Yeo, 1996).

1. Cardiovascular Disease and Diabetes. Evidence related to the risk for hypertension is contradictory. In the 1979 California Hypertension Survey, prevalence rates of uncontrolled hypertension for Filipino men and women over age 50 were 60% and 65%, respectively, compared to the U.S. prevalence rate of 47% for the same age (Stavig, Igra, & Leonard, 1984, 1988). In contrast, Cabral, Gusman, and Estrada (1981) reported low blood pressures among Filipinos living in the Philippines. Angel and associates (1989) found hypertension was less prevalent among U.S.-born Filipinos and suggest that their hypertension may be partly associated with the proposed sodium-load handling hypothesis (Woods, West, Weissberg, & Beevers, 1981). In a New Jersey survey of Filipino Americans, 23% reported having hypertension (Garde, Spangler, and Miranda, 1994).

Filipino immigrants are considered at risk of hypertension, coronary heart disease, diabetes at midlife and old age, and other metabolic problems (Anderson, 1983; Gerber 1980; Nora & McBride, 1996, Stavig, et al., 1988). Gerber (1980) reported that male Filipinos aged 55-64 years who were in Hawaii before 1931 had 61% higher death rate from coronary heart disease than men in the Philippines. Sloan (1963) found an age-adjusted prevalence of diabetes three times higher for Filipinos than whites in Hawaii.

2. Cancer. Regional differences are reported for breast cancer risk. Filipino women in Hawaii had the lowest risk at 29 per 100,000 (Goodman, 1991) while women 40 years and older in the San Francisco Bay Area had an age-adjusted risk of 119, much higher than black, Chinese, and Japanese women but lower than whites Northern California Cancer Center [NCCC], 1993b). Filipino women had the lowest survival rate of the five groups except blacks. Bay Area Filipino women had higher overall age-adjusted cancer incidence for all sites than the other groups except whites (NCCC, 1993b).

Rates in the Bay Area Filipino men for age-adjusted incidence of cancer in all sites are lower than most of the five groups compared but higher than Chinese and Japanese (NCCC, 1993a). Liver cancer among Filipino males and females was second only to the Chinese and three times higher than among whites (NCCC, 1993a, b).

3. Dementia. In nine California Alzheimer's Disease and Diagnostic Centers, Filipino cases accounted for a very small number (0.7%) of all screened in an 8-year period (Yeo & Lieberman, 1993) that suggests the need for vigorous case finding. Cognitive impairment may be associated with cardiovascular problems as Filipino American-age (Gerber, 1980, Stavig, et al, 1984; 1988). There are no studies of vascular dementia among Filipinos although hypertension has been shown to be high in the population.

4. Depression and Suicide. Geographic separation or alienation from family and financial difficulties are found to be common stressors among clinically depressed Filipinos (Tompar-Tiu & Sustento-Seneriches, 1995). Older Filipino men committed suicide more than women, mimicking the trend for the general population of older Americans (Diego, Yamamoto, Nguyen, & Hifumi, 1994). Compared to other Asian groups, the incidence of suicide is low among older Filipinos, probably due to the influence of Catholicism.

5. Elder Abuse. Based on reports of elder abuse filed in Adult Protective Services for several Northern California counties, one of the most vulnerable group are recent WWII Filipino veteran immigrants who relocated to the U.S. 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 Service through an investigative report. Action from the Filipino community strongly influenced correction of the problem (Chin, 1993a,b). Other potential cases of elder abuse have been investigated for public guardianship. Often families involved in such cases are uninformed of resources and believe that caring for their elder is their responsibility (Lewis, Sullivan, McBride, 2000).

6. Gout. High rates of hyperuricemia and gout are found among males, particularly in low to middle income groups in the Philippines (Torralba & Bayoni-Sioson, 1975).

7. Infectious Disease: TB and HIV. In 1993, 62% of the foreign born cases of tuberculosis (n=213) in Hawaii were immigrants from the Philippines, which may be explained by the fact that the Philippines is reported to have the highest incidence of TB among all countries (New World Order, 1994). Filipino WWII veterans who arrived after 1990 are at risk (Yamada, 1994), which may be related to their rapid entry into the U.S. under a waiver of the required health examinations. San Francisco Department of Public Health (SFDPH) data show that 39% of APIs with HIV were Filipinos (SFDPH, 1992). Although the number of elderly men with HIV is small, it is important to note that those who live alone or feel socially isolated are at risk.

B. Functional Status

There are no major national reports on functional status of older Filipinos. In New York, a group of widowed immigrant women aged 65 and older used functional capacity as their measure of wellness. How their abilities compared to their peers was a critical benchmark that influenced decisions to seek health care services (Valencia-Go, 1989).

C. Social Support

In Philippine society, multigenerational households are accepted arrangements where respect and love for parents and older family members are taught and expected of the children. Caring for aging relatives is integrated over time into these relationships, and interdependence is deeply embedded in the culture. Caring for others is a complex skill that is learned throughout the developmental stages of the Filipino personality (Enriquez, 1994). The National Media Production Center (1974) described the Filipino family as a unique and most able social system of care from birth to end of life. Traditional Filipino American families pass on this value to the new generation. Many contemporary families function within an extended family structure with strong emphasis on interpersonal dynamics, group harmony and loyalty, respect for elders and authority, and maintenance of a natural support system by a complex process of building interdependent/dependent relationships and family roles (McBride & Parreno, 1996; Superio, 1993; Tompar-Tiu & Sustento-Seneriches, 1995).

As Filipino American families experience acculturation, factors such as nativity, psychosocial and economic stress, and the level of affinity to traditional cultural values may influence the nature and quality of the support that is available to the older person.

III. Culturally Appropriate Geriatric Care: Fund of Knowledge

A. Cohort Experiences

A cohort refers to a group of individuals who share the same sociohistorical experiences over a period of time. Knowledge of historical experiences of Filipino cohort groups may provide health care providers with additional insights into an older person and the family members' responses to clinical encounters and the recommended plan of care. Knowledge of the immigration history of the population from the Philippines and the periods of greatest discrimination are important to understand the background and experiences of the current cohort of Filipino American elders.

1. Immigration History

a. **Early Period.** The first recorded settlement of Filipinos was in Louisiana during the Spanish galleon trade (1565-1815) that carried Philippine cargo. In 1763, members of the Filipino crew escaped forced labor and enslavement and made their way to New Orleans and established a community in the bayous. Known as "Manilamen", the Filipino cajuns and their descendants introduced wine making from coconut (*tuba*) and developed an export industry of sun-dried shrimp. From 1763 to 1906, others followed (e.g., mariners, adventurers, domestics) and as the community grew, some moved on to the West Coast and Hawaii or to Alaska to seek jobs in the fishing and whaling industry. A few upper-middle class travelers from the Philippines to Spain also chose to disembark and join the community.

b. **After the Spanish- American War (1898)** Filipinos became U.S. nationals and were able to live legally in the U.S. under the protection of its laws (Espina, 1974; Tompar-Tiu & Sustento-Seneriches, 1995). From 1900 to 1934, three subgroups of immigrants arrived, primarily in Hawaii and California. The *sakadas*, were young, poorly educated rural laborers who were recruited to augment or replace the Japanese workforce in Hawaiian plantations, intending to return home. Those who stayed, called the *manongs* (brothers), lived as bachelors in poverty and social isolation within the Filipino community. Now, the stories of the *manongs* are embedded in their legacy to their families. The *pensionados* came to the U.S. as government subsidized scholars and worked in a variety of low-paying jobs such as domestic work to support themselves. Some remained in the country and blended in with the later immigrants, the *pinoy*s, who came to seek economic prosperity or join their families. The *pinoy*s did farmwork in the San Joaquin Valley, Salinas, and Sacramento in California; factory work in the Alaskan fishing and cannery; and service jobs such as domestics, busboys, janitors. Considered an economic and social threat, the *pinoy*s had the most extensive experience with overt racism and discrimination including changes

in immigration policies, antimiscegenation laws, and oppressive farm management practices. Many migrant families lived in poverty, and children were pushed to get educated, speak English only, and mainstream quickly. Some of the Filipino elders and their family caregivers may have been part of this group (McBride et al., 1996; Tompar-Tiu & Sustento-Seneriches, 1995, Yeo, et al., 1998).

c. 1935- 1965. From 1935 to 1965, more Filipino women and families immigrated; they consisted of U.S. military dependents (war brides), WWII veterans, professionals, and students. The latter part of this period began the Philippine “brain drain”. They contributed to American society, despite significant experiences of economic exploitation and social injustice. The social change in the ‘60s triggered passionate dialogues in the Filipino American community about its sociocultural identity and ethnic legacy. An outcome was the use of “Pilipino” instead of “Filipino” as a sociopolitical label by a segment of the community rooted in activism as a means to social change. The Office of Civil Rights recognizes both labels and the use of “F” or “P” as determined by preference, although most elders use “Filipino”.

d. 1965- 1990. By 1965, more diversity occurred in the Filipino American community. Immigration included highly educated professionals (mostly young women in the health professions), family members such as grandparents or followers of adult children under the 1965 Family Reunification Act, and aging WWI veterans. Some professionals who are unsuccessful in getting professional licenses accept lower status employment in the health field and other areas, undergo retraining, or for a few – start a small business. In the mid-’70s, economic and political refugees from the Marcos regime and short-stay visitors (overseas contract workers, students, people in business, and tourists) added to the sociocultural, educational, economic, and political diversity of the community. Filipinos with short-term visas have 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 elder caregiver). Some retired, professional older Filipinos who join their families may seek these types of employment or become surrogate parents to their pre-school and school age grandchildren.

e. 1990 to the Present. The 1990 amendment to the Immigration and Naturalization Act brought an influx of aging WWII veterans who were given instant American citizenship because of the unfulfilled promise made to them for U.S. citizenship when they fought for the Allies in WWII. Almost 4000 are reported to reside in the West Coast, with a large number 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.

Family reunification continues, and Filipino immigrants now represent a wide range of background. The manpower shortage in the U.S. in health care and computer industries has been an attractive pathway for Filipinos to escape economic hardship and seek quality of life. The effects of acculturation on intergenerational Filipino families contribute to the heterogeneity within this population particularly in their values, health beliefs, health practices, and attitudes toward health care and social service programs.

B. Health Beliefs and Behaviors

There is limited research-based information on health beliefs, health behaviors, and cultural values for elderly Filipino Americans. Most of the information below was collected from studies that are specific to one health problem or health issue, dissertations and master's projects, and published summaries of scholarly materials from journal articles, book chapters, presentations at professional and scientific meetings.

1. Indigenous Health Beliefs

a. Principle of Balance (*Timbang*). This is a key indigenous health concept that includes a complex set of fundamental principles. A range of "hot" and "cold" beliefs concerning humoral balances in the body and food and dietary balances includes the following:

- Rapid shifts from "hot" to "cold" lead to illness.
- "Warm" environment is essential to maintain optimal health.
- Cold drinks or cooling foods should be avoided in the morning.
- An overheated body (as in childbirth or fever) is vulnerable; and heated body or muscles can get "shocked" when cooled suddenly.
- A layer of fat ("being stout") is preferred to maintain "warmth" and protect vital energy.
- Heat and cooling relate to quality and balance of air (*hangin*, "winds") in the body.
- Sudden changes in weather patterns, cool breezes or exposure in evening hours to low temperature, presence of hot sun immediately after a lengthy rain, vapors rising from the soil all may upset the body balance by simply blowing on the body surface (Anderson, 1983; McBride, et al., 1996; Orque, 1983).

b. Theories of illness. Physical and mental health and illness are viewed holistically as an equilibrium model. Explanatory models may include mystical, personalistic, or naturalistic causes (Anderson, 1983; Tan, 87; Tompar-Tiu & Sustento-Seneriches, 1995).

1) **Mystical** causes are often associated with experiences or behaviors such as retribution from ancestors for unfulfilled obligations. Some believe in soul loss and that

sleep related to the wandering of the soul out of body known as *bangungot*, or nightmares after a heavy meal may result in death.

2) Personalistic causes may be attributed to social punishment or retribution by supernatural beings such as an evil spirit, witch, or *mankukulam* (sorcerer). A stronger spirit such as a healer or priest may counteract this force. For protection, using holy oils, wearing religious objects or an *anting anting* (amulet or talisman) may be recommended.

3) Naturalistic causes include a range of factors from nature events (thunder, lightning, drafts, etc.), excessive stress, incompatible food and drugs, infection, or familial susceptibility.

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 that treats certain types of diseases. These two systems co-exist, and Filipino elders use a dual system of health care (Anderson, 1983; McBride, et al., 1996; Miranda, McBride, and Spangler, 1998).

c. Health promotion/treatment concepts. Beliefs are oriented towards protection of the body.

1) Flushing. The body is thought to be a vessel or container which can collect impurities and must be cleansed of debris by stimulating physiological events such as sweating, vomiting, expelling gas, or having appropriate volume of menstrual bleeding.

2) Heating. Related to balance described above

3) Protecting: a gate keeping system to guard the body.

d. Indigenous community resources. Cultural healers help to “protect” the body and treat supernaturally with herbal/medicinal treatments, incantations, and offerings. The *hilot* is a type of ancient tribal priestess. *Babaylan*, a common Filipino indigenous practitioner, uses three types of treatment: prayers and rituals, herbal plants, and massage/manipulation of bones and body tissues. A *hilot* usually is respectful of the value of medical care. An *arbularyo* (herbalist) has special treatment skills with liquid infusion and dietary measures.

2. Health Behaviors

a. Response to illness. Filipino elders may often follow a pathway to seeking professional health care that begins with self-monitoring of symptoms to ascertain possible cause, severity, threat to one's functional capacity, and economic and/or emotional inconvenience to the family. Options are considered to either discuss the concern with a trusted family member, friend, or spiritual counselor/healer, or to self-administer natural and commercial remedies (such as herbs, food, teas, nonprescription medicines, nutritional supplements). The extended trajectory from symptom onset to medical treatment may also be impacted by sociopolitical and historical experiences of injustice, racial or gender discrimination by the elders themselves, or by attitudes passed on to them by family members who had these difficult experiences (Yeo, et al., 1998).

Severe somatic symptoms such as pain, dizziness, sleeplessness, loss of appetite, physical incapacitation would motivate an elder and family members to seek advice and treatment from an indigenous diagnostician, a family member or friend who is a health professional, and/or formal medical care (Anderson, 1983). Interviews of older Filipinos age 50 and over with diagnosed chronic illness (diabetes, hypertension, arthritis, asthma, and cancer) attribute control of the disease to adherence to treatment, although the value of such health practice was oriented more towards their role in the family and the desire to participate more fully in family and group life. They also engage in self-care practices that include diet management, exercise (defined as walking, singing, dancing, socializing), use of herbal oils and liniments, and healing massages, or visits to healers (Becker, Beyene, Newsom, & Rodgers, 1998).

b. Health promotion and disease prevention. An equilibrium model stresses the importance of balance and moderation as key concepts to maintain health and prevent disequilibrium (i.e., diseases). Emphasis on cleanliness, orderliness, appropriate social conduct in various situations, and avoidance of social, emotional, or psychological distress helps to keep one's body strong.

Screening programs such as mammograms, Pap smears, PSAs, and blood tests for cholesterol and glucose are familiar medical terms to many elders, although their significance to health status may be poorly understood and internalized. Among intergenerational Filipino households, some elders' access to screening services may be facilitated, delayed, or rejected by adult family members who feel an obligation to protect their elders from external forces. Many Filipinos who immigrate as older adults to join their families, particularly those who have limited English proficiency and minimal adaptive skills for modern technologies in the host culture, tend to expect this role from adult children (McBride & Parreno, 1996; Miranda, et al., 1998; Sioson and Antes, 1988). Filipino Americans who "age in place" and have had extensive acculturation experiences may be

more apt to initiate screening appointments that fit their priorities and commitments. Older women who are active in church and religious activities tend to be more conscientious with keeping a health promotion program such as breast and cervical cancer screening (McBride, Pasick, Sabogal, et al., 1997; McBride, Pasick, Stewart, et al., 1998).

A group of older widowed Filipino women who immigrated to New York compared each other's functional capacities as indices to assess their level of wellness or change in health status. Mental health indices included independence and self-reliance over time, openness to new experiences, nurturing satisfying family and social relationships, being involved in physical activities (e.g., household chores, or recreation), practicing one's faith (attending church services), and learning and adjusting to the host culture. They used life experiences over knowledge to formulate wellness criteria (Valencia-Go, 1989).

3. Cultural Values

a. Interpersonal Relationships. Smooth interpersonal relationships are a major component of the Filipino core value *kapwa*, defined as "shared identity, interacting on an equal basis with a fellow human being." It is expressed as sensitivity and regard for others, respect and concern, helping out, understanding and making up for others' limitations, rapport and acceptance, and comradeship (Agoncillo & Guerrero, 1987; Enriquez, 1994). Traditional psychosocial interactions or *pakikipagkapwa* occur in the external domain or *ibang tao* and the internal domain or *hindi ibang tao*. Levels of relationships in the first domain consist of: civility (*pakikitungo*), mixing (*pakikisalamuha*), joining/participating (*pakikilahok*), and adjusting (*pakikisama*). The second domain includes: mutual trust/rapport (*pakikipagpalagayan ng loob*), getting involved (*pakikisangkot*), and oneness, full trust (*pakiisa*) (Enriquez, 1994; PePua, 1990).

b. Family and Filial Responsibility. Many contemporary Filipino American families continue to function in a complex process of a natural support system of reciprocity within interdependent/dependent relationships based on extended family membership, group harmony and loyalty, respect for elders and authority, and kinship that goes beyond strong biological connections (McBride & Parreno, 1996; Miranda, McBride, & Anderson, 2000; Superio, 1993; Tompar-Tiu and Sustento-Seneriches, 1995). In a study of filial responsibility, young first and second generation Filipino Americans and older adults strongly agree that children should be taught to care for elders and take care of aging parents (Superio, 1993).

c. Spiritual Life and Religiosity: A consistent theme in health and caregiving studies on Filipino Americans is the importance of prayer, church affiliation, spiritual fellowship, and spiritual counseling. Studies have shown that having the capacity to practice one's faith can be a measure of wellness (Valencia-Go, 1989). Using prayer and spiritual

counseling can be a part of a treatment plan with assistance from a traditional healer or a clergy (Tompar-Tiu & Sustento-Seneriches, 1995). Some elders and their families consider physical or emotional pain as a challenge to one's spirituality (Grudzen, McBride, & Thom, 2000). These findings are important indicators that a segment of Filipino American elders and their families incorporate and value a spiritual dimension in their daily life.

IV. Culturally Appropriate Geriatric Care: Assessment

A. Preparatory Considerations

1. Demonstrating Respect

a. Use of Miss, Mrs., or Mr. Calling by first name in a first encounter may be considered being too familiar with an older person. This is particularly important when the provider is young. With permission, providers may address patients who are aged 70 and older as "*Lola*" (grandma) or "*lolo*" (grandpa), but care should be taken in adapting this for older Filipinos who appear youthful.

b. Greeting. Use a firm handshake with a smile and eye contact. If older patients are with a family member, greet the older patient first. The social greeting "How are you?" translated into Tagalog, "*Kumusta po kayo?*" conveys respect because of the word "*po*".

c. Informal Conversation about grandchildren often puts the Filipino elder at ease. A clinician who shares briefly a personal anecdote particularly about children in her/his family may be perceived more as a human being to whom the elder can relate rather than as an authority figure.

2. Communication Issues

a. Verbal Communication

1). English proficiency. Many Filipino elders are proud of their ability to read, write, and speak English; consequently, they may feel insulted when asked if they need an interpreter.

2) Culture-based Communication Guide: The following contextual guidelines may be useful for clinicians in working with Filipino seniors:

- When the cadence and inflections in speaking English make it difficult to understand the patient, ask permission to seek interpreter service. To avoid

insulting the patient explain that the service is medical interpreting (as oppose to language interpreting) in order to reassure the clinician that the medical terms are accurately described to the patient.

- Questions such as “Do you understand?” or “Do you follow?” may be considered disrespectful. Instead, request the patient to repeat the instructions with explanation that the feedback process is for the clinician’s benefit to ascertain whether he/she has done a thorough job.
- Filipino elders who are used to high-context communication may feel puzzled and offended by the preferred precision and exactness of American communication process.
- Many elders, 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 the their health. Such 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.

b. Non- Verbal Communication

1) Pace of Conversation. Allow brief periods of silence in the encounter to enable the patient to process information that may be occurring in the native language (e.g. Tagalog) especially those with limited English proficiency.

2) Physical Distance. Observe usual personal space of 1 _ to 2 feet distance. Take height into consideration; seated position for interactions is highly recommended.

3) Eye Contact. Sit at eye level with patient for the interview; make brief and frequent eye contact, even though 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 higher social class. Prolonged eye contact by an older Filipino male patient with a younger female clinician may be flirtatious.

4) Emotional Responsiveness. Observe for changes in facial expressions; elders may sometimes appear to smile or chuckle inappropriately. Meaning of flat affect and downcast eyes during clinical interview should be explored.

5) Body Movement. Frequent hand gestures may be used by Filipino elders for emphasis. They may cover their mouths with one hand when speaking or smiling as an expression of shyness or embarrassment.

The common American gesture for “come here”, i.e., moving index finger pointed upward forward and back is an insulting gesture to less acculturated Filipinos. An acceptable gesture is to extend one hand towards the person with palm facing down and with four fingers (no thumb), flex and extend them several times.

Head nodding has many meanings, ranging from “I hear you” to “Yes I’ll cooperate”.

6) Touch. Young female service providers should practice discretion with regard to touching older Filipino male patients such as laying one’s hand on the patient’s hand or shoulder to reassure and comfort in moments of distress. Elderly Filipino women may spontaneously touch a hand or arm or hug a service provider to express appreciation for services rendered.

B. Use of Standardized Assessment Instruments

Except for an acculturation scale - *A Short Acculturation Scale for Filipino-Americans* (ASASFA) (de la Cruz, Padilla, and Butts, 1998), there are no known geriatric assessment instruments that have been validated and standardized for Filipino Americans. The ASASFA was standardized on a population of bilingual immigrants receiving health care at a Southern California Health Maintenance Organization, 77% of whom had college and advanced education.

C. Ethnogeriatric Assessment

1. Ethnic Affiliation and Acculturation.

- Assess participation in social, cultural, and educational activities in the Filipino community. Active memberships in local Filipino organizations may indicate extent of support network in the community. One might want to: 1) assess for indigenous tribal ancestry - e.g., muslim, negrito, malayan, mestizo, or 2) assess for multi-racial background - a legacy from pre-colonial trade with Asian countries, colonialization by Spain, presence of U.S. after the Spanish-American war; and the Filipino diaspora.
- Ascertain language preference for interview and written health information. Five-point Likert scale would be easy to administer clinically on two items that were shown to be significant predictors of acculturation - language preference and 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), items based on the ASASFA study (see above).

2. Religion. Assess how elder practiced religion prior to relocating to U.S. and under current situation; determine importance of church activities, rituals, and spiritual support to patient's sense of well-being (Valencia-Go, 1989)

3. Patterns of decision-making. Cultural values emphasize group harmony and smooth interpersonal relationship; decision making may be shared among family members according to patient's needs. Clinician 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 referred to family members living outside the U.S., or birth order may be used to designate decision maker (McBride & Parreno, 1996; Tompar-Tiu, & Sustento-Seneriches, 1995;). Ask questions such as "Who should we talk to who can help with making decisions about your treatment in the future?" Family members are often expected to make decisions or speak for the elder; those without family may rely on friends, clergy, or a trusted service provider. In complicated situations, a "go-between" who is usually not a family member may facilitate the interaction or dialogue, such as a trusted friend (*compadre/comadre*), clergy or member of a faith organization.

D. Clinical Assessment Domains

1. Health and Social History

a. Medication Review. Chronic use of prescription medication obtained from the Philippines or hoarding of unused medication may be found (SFDPH, 1993).

b. Situational Depression. Indicators may include history of immigration (e.g., post-1990 WWII immigrant), social isolation, role and function in household (e.g. surrogate parenting), or limited current financial resources (McBride et al., 1996; Tompar-Tiu, and Sustento-Seneriches, 1995).

c. Risk for Elder Abuse. Indicators may include less acculturation; living with non-family members or in an intergenerational household; dependence on other adults to move about; lack of ability to use simple technology (e.g., telephone); lack of English proficiency; and physical appearance (i.e., self-neglect) (Lewis, Sullivan, McBride, 2000). Newly arrived WWII veterans are prime target for sexual exploitation.

d. Use of Community-based Healers and Spiritual Counselor. Traditional treatment (herbal, nutritional supplements, prayer, etc.) often can be continued with medical treatment (Grudzen & McBride, 2001; McBride, et al, 1996).

e. Other Sources of Health Care. Medical care from a physician in the Philippines or other locations may be found among elders who frequently travel to the Philippines or visit other family members in the U.S.

f. Immunization History. Elders may not have received hepatitis B vaccine in their lifetime and/or may be uninformed about it.

2. Physical Examination and Screening Tests

a. Cardiovascular Evaluation. Cardiovascular risk is related to the following issues: Many traditional meals are prepared with salty condiments, pork fat, or coconut milk. Affordable and easy access to processed food in U.S. compared to the Philippines entices new arrivals quickly to become consumers. Physical activity for cardiovascular health is often defined as functional activities (e.g., household chores, gardening, babysitting).

b. Metabolic Conditions. Evaluate for gout, risk for diabetes, history of pancreatitis, liver problems associated with alcohol intake (*tuba*, Philippine beer, and hard liquor).

c. Gynecologic and Breast Exam. Some older women had home births and may not request an exam and a Pap smear. Some deeply religious Catholic women may consider touching their breasts a sin; for other highly traditional women self-exams may violate sense of respect for one's body. A female provider is usually preferred for these exams although a male physician who communicates sensitivity, respect, and gentleness would be acceptable. Avoid a hurried environment. Explain slowly using simple language before, during, and after procedures. Ask permission to perform examinations.

d. Tuberculosis. The required health exam was waived for WWII veterans who entered the U.S. after 1990. Positive TB tests can be expected from almost all elders. Check for active infection. (In the Philippines chest x-rays are usually done, and no treatments given with a negative result.) Prophylactic treatment may be refused; if accepted, start with low dose to minimize adverse effects and compliance problems.

e. Vision/Hearing. For low-income elders, priority to correct or treat sensory deficits is very low; such losses may be accepted as part of the aging process.

f. Cognitive and Affective Status. Stigma and shame (*hiya*) may delay access to diagnostic and treatment resources for Alzheimer's disease and mental health problems. Highly acculturated families may reluctantly seek resources. Public image of family is a 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 depressive symptoms. There is generally more confidence in medication than talk therapy. Spiritual counseling and prayer (clergy and healer) by trusted clergy, lay minister, or healer may be preferred. There may be a strong belief in Christ as a healer and God as “divine physician” (Grudzen & McBride, 2001). Family therapy or group therapy may be too threatening to less acculturated elders.

g. Functional Status. Build assessment around family and social activities. List activities on a typical day for greater accuracy. Because of cultural value of interdependent/dependent relationships, IADL scales may not be culturally appropriate; driving skills, use of check book, use of household appliances are skills that traditional and low income immigrants may not learn to perform in the U.S. if they are living in the same household as their adult children.

h. Family and Community Assessment. Elders could be living in a group setting with unrelated adults, in an extended family, with spouse, or living alone. Many newly arrived WWII veterans are separated from their families, and new kinships are developed through group living; the Filipino community monitors this subgroup through organizations. Highly acculturated elders (who age in place) may be isolated from the Filipino community. An extended Filipino family may include non-biological members such as godparents, parish priest, or a grandchild’s first grade teacher; integration into the family system happens slowly as individuals become known and trusted.

A health professional may be designated as spokesperson by default; almost all families have someone employed in the health care industry. Children are taught filial responsibility and respect for elder; lack of support may be perceived when adult children have two or more jobs. Sense of social isolation may be interpreted by elder as family rejection, lack of respect, lack of love, being unwanted, etc. -- assumptions that border around psychological neglect.

Depending on resources, elders may take periodic trips to the Philippines or visit adult children in various parts of the U.S. Circulating videotapes are popular means to communicate with family members

Characteristics of the urban or suburban neighborhood that might be important would be: availability of public transportation, Asian business, and Asian or Filipino food products in grocery stores; proximity of residence to senior center, church, and recreational facilities; degree of integration of neighborhood; and size of Filipino American population; crime rate; air quality; availability of services such as popular recreation of Filipino seniors - dancing, picnic/barbecue, popularity contests followed by award and dinner/dances; and

support from neighborhood and community such as neighborhood watch program. Suburban living or inter-racial households may create a sense of social and cultural isolation.

i. End-of-Life Preferences. Elders and family may avoid talking about advance directives or dying as some believe this may bring the event at their door. It would be best to approach a discussion gradually and in the presence of a trusted physician or clergy, or health care professional who is a family or extended family member.

In intergenerational families, elders may hesitate to express preference for death at home or in hospital in consideration for the need of the family. Memorial services may be organized by Filipino community organization, or in some cases the Philippine consulate, if elder is without family. Open discussion of rituals is rare although some highly acculturated elders may have something in writing.

Many Catholic elders believe the body must be kept intact for the promise of resurrection so that organ donation and autopsy would be difficult; body parts that are surgically removed should also be buried.

C. Problem Specific Data

1. Explanatory model. (See discussion in Module IV of Core Curriculum in Ethnogeriatrics) Physician is usually perceived as the expert; when eliciting explanatory model/patients perception of problem. Questions to ask could include: What circumstances led to the problem? Tell me about the problem/symptom. What remedies have you used so far to help you to feel better? Before coming to the clinic/hospital, what advice have you received for the problem? What can family members do to help with your recovery? Is there something you would like me to do for you in addition to prescribing medication? What important results should we be aiming for? How much time do you feel you need to recover from this problem?

IV. CULTURALLY APPROPRIATE GERIATRIC CARE: PREVENTION AND TREATMENT

A. Health Promotion Strategies

1. Recommended Screening: blood pressure; cancer (breast, cervical, prostate, liver); cholesterol; cognitive impairment associated with vascular changes; depression (situational); diabetes and diabetic retinopathy. In administering Pap smears, and colon cancer screening, sensitivity and avoiding using humor to reduce tension are recommended.

2. Recommended Immunizations and Prophylactic Treatments: tuberculosis, hepatitis B, hormone replacement.

3. Counseling. Counseling for substance abuse, elder abuse and self-neglect, nutrition, exercise, STD/HIV, smoking cessation, and osteoporosis prevention may be needed.

4. Health Education. For those who are linguistically isolated or monolingual, informational materials in Pilipino (Tagalog) with an English version are preferred.

B. Issues in Treatment and Response to Treatment

1. Informed Consent. Discussion of adverse outcomes and contingencies may provoke anxiety; it may also suggest to the elder a lack of caring from service provider.

2. Terminal Illness. Use indirect approach when discussing a terminal diagnosis for the first time; give information in small doses and in stages (McBride et al, 1996).

INSTRUCTIONAL STRATEGIES

In addition to lecture, discussion and reading assignments, learners can be assigned to do the following:

1. Interview an immigrant Filipino elder about her/his experiences in the US and write a short paper (3-5 pages). (See suggestions in Appendix C of the Core Curriculum in Ethnogeriatrics.)
2. Read an article or book chapter on Filipino Americans and write a paper (3-5 pages) relating the central theme to health and aging in the U.S. For example:

Santos, B. (1992) Immigration blues. In B.Santos (ed.) Scent of apples, a collection of stories. Seattle, Washington: Washington University Press, 3-20.
3. Interview a health care provider or a peer about their perception on health behavior and health practices of older Filipino Americans and write a paper (3-5 pages).
4. Interview a Filipino family about their caregiving experience and write a paper (5 pages) focusing on the cultural values and beliefs associated with the caregiving.
5. Small Group Work: In small work group, analyze effects of public policies on the Filipino elder's immigration, employment, and quality of life. Each group selects a topic such as the 1990 amendment to the Immigration and Naturalization Act; Anti-miscegenation Law, etc. Present and/or write a two-page report on their conclusions.
6. Discussion of Videotape: Ow, G., Dunn, G., and Schwartz, M. (1984) Dollar a Day; Ten Cents a Dance: A Historic Portrait of Filipino Farmworkers in America. Demonstration Project for Vision Communications, Impact Production, Producers.
7. Role Play: Culturally appropriate interaction with a Filipino elder. Specific situation may be designed from the Case Vignettes.

In addition the following cases can be used to initiate discussion on the topics included in the module. They can also be used for written assignments.

Case of Mr. B.

Mr. B., a 67-year-old married Filipino, was at the primary care clinic for post-stroke follow up, accompanied by his wife and daughter. He had been discharged from the hospital two weeks ago after acute rehabilitation for right-sided hemiplegia. Optimum functional return is expected with continued home rehabilitation services from the Visiting Nurses Association.

On examination, Mr. B., showed early signs of contractures on the right upper extremity, particularly the hand. His blood pressure is under control with medication. He feels he is recovering well and is pleased that his family, especially his wife and daughter are available to help him with ADLs. He complained that the home care nurse expects too much from him and tries to discourage his family members from taking care of him.

His wife and daughter explained that the patient gets easily frustrated, especially with dressing activities. They worry over the possibility of another stroke when Mr. B gets agitated. Mr. B believes that older people should be cared for by their family and should do what they can to make the elder comfortable.

Discussion Questions:

1. What cultural values could explain the patient and family's behaviors?
2. How can the home care nurse align the rehabilitation goals with the goals of Mr. B's and his family?

Case of Mr. S.

Mr. S., an 87-year-old widowed Filipino has been on home care for two weeks after a right leg below-the-knee amputation due to diabetes. His upper extremities are weak, although he can move about easily in his wheelchair. He is hard of hearing on the left ear; speaks very little English; and depends on his family to advocate for his needs. He lives with two unmarried sons who take turns staying home from work until a suitable caregiving arrangement is made. The sons immigrated in the early 70's and Mr. S. followed after his wife died in 1978. The oldest son feels strongly that the family should take care of Mr. S. He hopes to hire a female Filipina home health aide. The service is partly covered by Medicaid, and the rest will be paid from the family income generated from part time employment.

Discussion Questions:

1. Identify and discuss the risk factors for elder abuse or mistreatment in this case?
2. What culturally appropriate measures can a case manager consider to prevent abuse or mistreatment?

Case of Mrs. H.

Mrs. H., an 80-year-old Filipino immigrant woman with a chief complaint of “tiredness”, was referred by her primary care physician for psychiatric evaluation. This was her first time to see a psychiatrist. She was accompanied by her son, his wife, and two children to consult Doctora - the “Nerve Doctor” who is second generation Filipino. Mrs. H. was disappointed that Doctora could not speak Ilocano, and the interview was conducted with help from the adult family members. Her son, an accountant, who immigrated after graduating from a well- respected university in the Philippines explained that for the past year since Mrs. H. arrived in Honolulu from Chicago to live with his family, she has gradually withdrawn, keeping to herself in her bedroom most of the time. She would become animated when getting ready for church and would socialize with the family after church services. She would repeatedly tell stories about her church activities in Chicago and the Philippines until the family, especially the grandchildren age 11 and 13, would gradually focus their attention on other activities. When she offers to prepare lunch, her daughter-in-law helps out in the kitchen. The family lives in a three-bedroom apartment located close to a bus line and a small grocery store.

With the patient and son’s permission to assist as interpreter, the interview began by asking the patient to share something about her life in the Philippines. Mrs. H grew up in a rural community where her family farmed the rice fields with members of the extended family - aunts, uncles, cousins, and in-laws. She reminisced about the festivities in her village to honor saints who help with a good harvest; the special dishes prepared for the occasion; and her homebirth experiences with four children assisted by a local midwife. The physical exam showed no evidence of dementia, and Mrs. H.’s symptoms did not meet the criteria for clinical depression. When she was informed that she did not require hospitalization and was not “crazy”, she relaxed and became more conversant telling the doctor that no one in her village had ever been to a “nerve” doctor. After speaking with the son and daughter-in-law in private, Mrs. H was prescribed a multivitamin tablet.

Discussion Questions:

1. What cultural and environmental factors contribute to Mrs. H’s somatization?
2. What would you recommend to Mrs. H’s family to prevent social isolation?
3. What are the implications for primary care providers of Mrs. H’s complaint or tiredness and her attitude towards psychiatric care?

STUDENT EVALUATION

Performance can be evaluated by:

Objective Tests (true/false; multiple choice)

Paper on interviews, results of group work

Representation of cultural themes in the role-play

Sample Test Questions:

1. When assessing recent immigrant patients who are Filipino WWII veterans, major health problems to check for includes:
 - a. Diabetes and hypertension
 - b. depression
 - c. tuberculosis
 - d. b and c
 - e. none of the above

2. To facilitate trust building and communication in a clinical interview, the provider should consider using these approaches (circle all that apply):
 - a. share a story about your family
 - b. always ask if a language interpreter is needed
 - c. address the older patient with a formal title such as Mr., Mrs., or Miss
 - d. Ask about patient's family members especially grandchildren
 - e. sit at eye level during interview

3. Validated predictors of acculturation level for bilingual and highly educated Filipino elders includes (circle all that apply):
 - a. self-identified cultural identity
 - b. preference for reading materials
 - c. language spoke at home
 - d. preference for traditional Filipino meals
 - e. living in an intergenerational household

4. What sociopolitical events led to an influx of older immigrants to the U.S.? (circle all that apply)
 - a. social revolution of the '60s
 - b. martial law in the Philippine in the '70s
 - c. 1965 Family Reunification Act
 - d. 1990 Amendment to the Immigration and Naturalization Act
 - e. end of WWII

Objectives	Evaluation
Describe major sociodemographic characteristics of the Filipino American community and their elderly.	Test; paper
Identify significant historical and sociopolitical events that influence U.S. immigration of Filipino elders.	Test, paper
Discuss the major sources of health data, gaps in information, mortality and morbidity rates, and health problems for this group.	Test, paper
Identify at least five critical areas for health assessment, screening, and intervention.	Test, paper
Describe living arrangements and patterns of social support of older Filipino Americans.	Test, paper
Identify at least five cultural factors that affect the interaction of older Filipinos with the health care system.	Test, role play, paper
List at least five culturally acceptable approaches that could facilitate communication and trust building between a less acculturated elder and a service provider.	Test, role play

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INSTRUCTIONAL VIDEOTAPE

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