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Melissa Dimalanta Camorongan  
Factors Affecting Help-Seeking  
Behaviors for Mental Health  
Services Among Filipino Americans

ABSTRACT

This qualitative study explored help-seeking behaviors for mental health services among Filipino Americans. Filipinos are the second largest Asian American population in the United States and have been identified as one of the high-risk Asian American groups for mental disorders. Yet as a population they remain understudied and underserved. Existing studies are quantitative and have been conducted on college age students that are transitioning to adulthood. We know little about the help-seeking behavior for mental health services among Filipino Americans in adulthood and in their own voice.

This study involved face-to-face interviews with a sample of 12 persons of Filipino ancestry that were over the age of 22 years, currently living in the United States, and English speaking. This sample of convenience was skewed towards Filipinos that were foreign-born naturalized citizens, well educated and affluent.

The major findings were that positive sentiments about and high utilization of mental health services by the sample was inconsistent with the literature that suggests utilization of mental health services is highly stigmatized among Filipinos. Those who sought counseling did so for problems with intimate partner relationship conflict. Consistent with the literature, the cultural norm of “saving face” was identified as the greatest impediment to seeking mental health services among Filipinos, yet there was

little to suggest that mental health services were stigmatized or that saving face was an issue for this sample. The need for culturally specific outreach and targeted education about mental health needs and services in the Filipino community was identified.

FACTORS AFFECTING HELP-SEEKING BEHAVIORS  
FOR MENTAL HEALTH SERVICES  
AMONG FILIPINO AMERICANS

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work

Melissa Dimalanta Camorongan

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Northampton, Massachusetts 01063

2007

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To my parents, Mario and Pat Camorongan: Thank you for teaching me the importance of remembering where you came from, and continuing to give back to the community. To my siblings, Lynn, Matt, and Nica: Thank you for your support, your laughter, and for being with me through my struggles and successes. You are the best people I know, and I am so grateful for you all. To Cyruz Perez: Thank you for your willingness to help always.

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## CHAPTER I

### INTRODUCTION

Although Filipino Americans have been identified as one of the high-risk Asian American groups for mental disorders (Tompar-Tiu & Sustento-Seneriches, 1995), as a population they remain understudied and underserved. This neglect is all the more remarkable since Filipinos are now the second largest Asian American population in the United States and Filipino immigration to the United States continues to grow. Yet despite their growing numbers and being at high risk for mental disorders, there is evidence to suggest that most Filipinos do not seek any help for their mental health issues; and that those who do are far more likely to use lay systems, the general medical sector or folk support systems when they do seek help for mental health issues (Gong, Gage, & Tacata, 2003). Thus the need to know more about what factors determine help-seeking behavior for mental health services among Filipino Americans is all the more urgent and has been identified in the literature (Agbayani-Siewart, 1994; Abe-Kim, Gong, & Takeuchi, 2004; David & Okazaki, 2006; Gong, Gage, & Tacata, 2003).

What we do know from the limited body of existing research on Filipino Americans is that Filipino youth have one of the highest rates of suicidal ideation and suicidal attempts in the United States (President's Advisory Commission on Asian Americans and Pacific Islanders, 2001), and that depression is more prevalent among this ethnic group than the U.S. general population (Tompar-Tiu & Sustento-Seneriches,

1995). Additional health/mental health issues among Filipinos in the United States are high rates of eating disorders, unintended pregnancies, sexually transmitted infections, and drug use (Nadal, 2000). There is also some suggestion that the help-seeking behavior of Filipinos is strongly influenced by indigenous and cultural beliefs, language, conflicts between Filipino and American cultural beliefs, ethnic identity development and colonial mentality (David & Okazaki, 2006; Tompar-Tiu & Sustento-Seneriches, 1995; Edman & Johnson, 1999; Nadal, 2004; Gong, Gage, & Tacata, 2003; Wolf, 1997; Rimonte, 1997).

On the other hand, it is equally important to note that the limited state of our knowledgebase about the mental health needs of the Filipino community in the United States is not the exception but the rule. Our cumulative knowledge of the mental health needs of all Asians populations living in the United States is also very limited. What is known is that Asian Americans have the lowest rates of utilization of mental health services among people of color living in the United States, and that the severity of disturbance among Asian Americans who seek mental health services is high. Research suggests that factors such as shame/stigma over using mental health services, lack of financial resources, conceptions of health and treatment that differ from Western views, cultural and linguistic inappropriateness of services, and use of alternative resources within Asian communities may affect help-seeking behaviors for mental health services among Asian Americans, thus contributing to their low rates of mental health utilization (U.S. Department of Health & Human Services, 2001).

However, it is important to recognize that the Asian populations in America are richly diverse within themselves, even though they may share many common elements in their worldview that set them apart in discernable ways from the mainstream. Chinese,



Filipinos, Asian Indians, Vietnamese, Koreans, and other Asians, have emigrated from countries with unique histories and cultures. They also immigrated in large numbers at different times in the history of the United States, faced different challenges and opportunities, and made different accommodations (Nimmagadda & Balgopal, 2000; U.S. Department of Health & Human Services, 2001). Because data regarding Asian Americans reflect such a wide range of different Asian experiences, it is imperative that studies focusing on specific ethnic groups within the Asian American Diaspora are conducted in order to better understand any differentials in mental health needs, as well as population-specific factors that might affect help-seeking behavior for mental health services and contribute to the low rates of utilization.

This qualitative study was designed to make its contribution to filling this gap by exploring the help-seeking behaviors for mental health services by Filipinos in the United States with a sample of convenience drawn from the San Francisco Bay Area where I was placed. It is my hope that the findings of this study will assist the mental health community in fine tuning its outreach efforts and improving the delivery of mental health services to the Filipino community.

## CHAPTER II

### LITERATURE REVIEW

#### *Overview of Asians in America*

Asian Americans are not a homogenous group, reflecting instead a wide array of diverse ethnic groups. In fact, the term “Asian Pacific American” refers to 43 different ethnic groups, including 28 Asian groups and 15 Pacific Islander groups (Lee, 1997, p.4). Similarly, immigration history, length of time in the United States, and settlement patterns in the United States also differ among Asian groups, and there have been discrepancies in the accounts of which groups were the first to arrive, and when these arrivals took place. What has been most frequently noted as the beginning of Asian immigration to the United States is the arrival of Chinese immigrants during the late 1700s (Lee, 1997; U.S. Department of Health & Human Services, 2001). There have been other accounts that indicate that Filipinos first arrived in the United States in 1587, when a Spanish galleon entered Morro Bay in California (Pido, 1997). The first recorded settlement of Filipino Americans was in the Louisiana bayous in 1763 (Nimmagadda & Balgopal, 2000; Pido, 1997; Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995). Regardless of which group is credited for the initial arrival to the United States, the first major Asian immigration to the United States took place during the 1700s, and continued until 1924, primarily to fill in the need for cheap labor in the United States (U.S. Department of Health & Human Services, 2001). This included the

immigration of 300,000 Chinese to the West Coast between 1848 and 1882 to mine gold, many of whom arrived as indentured servants (Nimmagadda & Balgopal, 2000; U.S. Department of Health & Human Services, 2001); the arrival of Japanese contract workers in Hawaii in 1868 to work on sugar plantations; and the arrival of 7,800 Koreans to work on Hawaiian plantations in 1903 (Nimmagadda & Balgopal, 2000). Filipinos also joined the U.S. labor force, when they were recruited to work on pineapple fields in Hawaii and various farms on the West Coast between 1906 and 1934 (Sustento-Seneriches, 1997; Tompar-Tiu & Susteno-Seneriches, 1995).

Asian immigration to the United States was not only affected by the need for labor, but also by exclusionary laws prohibiting immigration of certain groups at different times in U.S. history. In 1882, the Chinese Exclusion Act suspended immigration of Chinese laborers for 10 years, resulting in the exclusion of Chinese for citizenship by naturalization; this was followed in 1892 by the Geary Act, which prohibited Chinese immigration to the United States for another 10 years (Nimmagadda & Balgopal, 2000). In 1908, Japan and the United States reached a “Gentleman’s Agreement” whereby Japan stopped issuing passports to laborers wanting to immigrate to the United States (Nimmagadda & Balgopal, 2000; U.S. Department of Health & Human Services, 2001). In 1924, the Immigration Act ended Asian immigration to the United States completely, declaring that no one ineligible for citizenship may immigrate to the United States. This included Japanese and Asian Indians, who were declared ineligible for naturalized citizenship by court rulings in 1893 and 1923, respectively (Nimmagadda & Balgopal, 2000; U.S. Department of Health & Human Services, 2001).

However, because the Philippines had become a United States Protectorate in 1898, Filipinos continued to immigrate to the United States, primarily as daily wage laborers in California, until 1934, when the Tydings-McDuffie Act of 1934 limited the annual quota of Filipino immigrants to fifty per year (Tompar-Tiu & Sustento-Seneriches, 1995; U.S. Department of Health & Human Services, 2001). Also during this time period, the Legislative Act of 1925 declared that Filipinos were ineligible for citizenship unless they had served 3 years in the U.S. Navy (Nimmagadda & Balgopal, 2000).

In 1965, the Immigration Act was passed, which abolished the national-origins quota system, favored family reunification, and discouraged systematic discrimination against Asians (Nimmagadda & Balgopal, 2000; U.S. Department of Health & Human Services, 2001). The result was the immigration of a large number of Chinese, Korean, and Filipinos to the United States (The majority of Japanese living in the United States today are the descendants of Japanese who immigrated to Hawaii or the U.S. mainland prior to 1924) (Lee, 1997). The fall of Saigon and the end of the Vietnam War in 1975 signaled the arrival of large numbers of Southeast Asian refugees, including mostly-educated Vietnamese (Lee, 1997; Nimmagadda & Balgopal, 2000). In 1978, a second-wave of refugees came to the United States to avoid persecution, and included Vietnamese, Chinese-Vietnamese, Cambodians, Lao, Hmong, and Mien (Lee, 1997). Future Asian immigration to the United States will largely depend on the political situations in each country, and “the ever-changing U.S. immigration policies” (Lee, 1997, p. 5).

Currently, in the United States, Asian Americans and Pacific Islanders (AA/PI) as a population are a fast-growing racial group, growing 95% from 1980 to 1990 and 44% from 1990 to 2000 (U.S. Census Bureau, 2001b). Current census data from U.S. Census 2000 indicates that Asians comprised 11.9 million people, or 4.2% of the population. This included 10.2 million people, or 3.6% who reported only Asian and 1.7 million people, or .6% who reported Asian and at least one other race (Reeves & Bennett, 2004). Of the different Asian groups reported, five groups numbered one million or more, and constituted 80% of the Asian population in the United States. These groups are: Chinese, 23.8%; Filipino, 18.3%; Asian Indian, 16.2%; Vietnamese, 10.9%; and Korean, 10.5% (Reeves & Bennett, 2004). Six groups collectively accounted for 15% of the Asian population. These groups are: Japanese, 7.8%; Cambodian, 1.8%; Hmong, 1.7%; Laotian, 1.6%; Pakistani, 1.5%; and Thai, 1.1%. The remaining Asian groups were subcategorized as Other Asian, and accounted for 5% of the population (Reeves & Bennett, 2004). Most of the total Asian population currently living in the United States was foreign-born (68.9 %) and thus relatively recent immigrants. Specifically, 32.4% immigrated between 1980 and 1989, 43.5% immigrated between 1990 and 2000, and only 42.1% immigrated before 1980 (Reeves & Bennett, 2004).

Like their differing immigration patterns and history, different Asian American groups have achieved differing statuses in regards to education, employment, and income. For the data regarding education of people over the age of 25 years old, Asian Indians have the highest rate of post-high school education (76.4%), followed by Filipinos (72.4%), Koreans (64.7%), Chinese (63.9%), and Vietnamese (42.8%) (Reeves & Bennett, 2004). Compared to the U.S. general population, Asian Indians, Filipinos,

Koreans, and Chinese each had higher levels of post-high school education than the total U.S. population over the age of 25 years (51.8%). Asian Indians, Filipinos, and Koreans also fared better than the general Asian population in U.S. in regards to education (64.6%) (Reeves & Bennett, 2004).

With regards to employment, the U.S. Census (2000) divides occupation into six groups: (1) management, professional, and related; (2) service; (3) sales and office; (4) farming, fishing, and forestry; (5) construction, extraction, and maintenance; and (6) production, transportation, and material moving. Based on these categories, the largest percentage of workers among Chinese, Filipinos, Asian Indians, and Koreans were primarily concentrated in two sectors: management, professional, and related; and sales and office. The only exception in the five largest Asian groups was the Vietnamese, whose workers were primarily focused on production, transportation, and material moving (28.8%); and management, professional, and related (26.9%). In regards to employment, 4 out of 5 of these groups had workers primarily in the management, professional, and related sector. This included Asian Indians (59.9%), Chinese (52.3%), Koreans (38.7%), and Filipinos (38.2%). Each of these groups had more workers in this sector than the U.S. general population, which was 33.6%. However, only Asian Indians and Chinese had more workers in this sector than the general Asian population in the U.S., which was 44.6% (Reeves & Bennett, 2004).

With regards to median family income in 1999, U.S. Census (2000) indicates that Asian Indians had the highest median family income (\$70,708), followed by Filipinos (\$65,189), Chinese (\$60,058), Koreans (\$47,624), and Vietnamese (\$47,103). Asian Indians, Filipinos, and Chinese had a higher median income that year than the median

income of U.S. families in general (\$50,046) and the median income for Asian families (\$59,324) (Reeves & Bennett, 2004).

Despite the overall gains that Asians have made in educational, occupational, and financial realms, many needs still exist regarding Asians in the United States. It is particularly alarming that in 1999, only 3 Asian groups experienced less poverty than the general U.S. population (12.4%). This included Asian Indians (9.8%), Japanese (9.7%), and Filipinos (6.3%). All other Asian groups experienced higher poverty rates than the general U.S. population, ranging from 13.5% (Chinese) to 37.8% (Hmong) (Reeves & Bennett, 2004). Furthermore, “most recent Asian immigrant and refugee groups (e.g. Vietnamese, Cambodian, and Lao) are still struggling with language and cultural barriers and often face economic difficulties. The so-called model minority image of Asian Americans is a myth” (Lee, 1997, p.7).

#### *Asian Cultural Commonalities*

Although Asian Americans are a heterogeneous group, there are certain cultural characteristics common among ethnic groups in this racial category. Historically, the teachings of Confucianism and Buddhism have greatly influenced Eastern philosophy and approaches to life and family interactions. Traditional Asian families place a higher value on the family unit than the individual; the individual is seen as a product of all the generations of one’s family. As a result, individual achievements bring praise and credit to the family as a whole and not to the individual member (Lee, 1997; Nimmagadda & Balgopal, 2000). Harmony and loyalty is also emphasized among Asian cultures. This can be seen through the values of filial piety and saving face (Nimmagadda & Balgopal,

2000). Filial piety is described as obligations and loyalty that the individual has towards one's parents, family, and ancestors, while saving face is the notion of acting and interacting with others that promotes pride and honor to the family. For traditional Asian cultures, this means that "an individual is expected to function in his or her clearly defined roles and positions in the family hierarchy, based on age, gender, and social class" (Lee, 1997, p.7). Although saving face promotes pride and honor to the family, a loss of face is any action that is seen as bringing shame to the family. Since harmony and loyalty are held in such high regard among traditional Asian cultures, shame, or loss of face, and family obligations are traditionally used to help reinforce societal expectations and proper behavior (Lee, 1997).

#### *Social Work Practice with Asian Americans*

One of the most significant implications for social work practice with Asians is working with clients within their cultural contexts. Among traditional Asian cultures, mental illness is highly stigmatized and looked upon as character flaws and as poor reflections of one's family lineage (U.S. Census, 2000; Nimmagadda & Balgopal, 2000). Because Asian cultural values promote harmony, negative emotions are usually suppressed "in favor of willpower and self-control" (Nimmagadda & Balgopal, 2000). As a result of this belief, Asians suffering any emotional or psychological distress are looked upon as having character flaws because of their inability to use willpower and self-control to contain or regulate emotional or psychological distress. Furthermore, since the expression of negative emotions is contrary to Asian cultural beliefs, it makes it increasingly difficult for Asians to talk about emotions at all. This often results in



somatization, the physical expression of psychological distress or discomfort which, for people of Asian descent, is the more socially and culturally acceptable manner of expressing negative emotions (Nimmagadda & Balgopal, 2000).

The implications for social workers, then, are to foster greater understanding of Asian cultural beliefs in their work with their clients. This can be done through culturally sensitive communications, identified by Dungee-Anderson and Beckett as “(1) acknowledge cultural differences, (2) know self, (3) know other cultures, (4) identify and value differences, (5) identify and avoid stereotypes, (6) empathize with persons from other cultures, (7) adapt rather than adopt, and (8) acquire recovery skills” (Dungee-Anderson & Beckett in Nimmagadda & Balgopal, 2000, pp. 53-54). Furthermore, because Asian cultures value interdependence and place high priority and regard on their relationships with their families, help is usually sought from immediate family members, followed by extended family members, then by community leaders (Nimmagadda & Balgopal, 2000). For this reason, social workers should be sensitive to the difficulty Asians encounter when seeking help for mental health services, and understand that often times professional help is sought only as a last resort. Social workers should also be open to involving family members in the treatment of clients when appropriate, as the priority of interdependence on family members may provide support needed by the client in order to get well.

### *Mental Health Needs of Asian Americans*

Knowledge of the mental health needs of Asians living in the United States is very limited (U.S. Department of Health & Human Services, 2001). What is known is

that Asian Pacific Americans have the lowest rates of service utilization of mental health services among ethnic populations in the United States, and those who utilize services experience a high rate of disturbance (U.S. Department of Health & Human Services, 2001). This is likely attributed to the delay of help-seeking for mental health services until symptoms are serious and seeking mental health services is a last resort (U.S. Department of Health & Human Services, 2001).

The most common mental health problems that have been identified among Asian Americans are “depression, somatization, anxiety disorder, adjustment disorder, and suicide” (Lee, 1997, p.13). In a study conducted by Sue and Sue (1974), Chinese Americans and Japanese Americans were found to have reported more somatic complaints than European-Americans on the Minnesota Multiphasic Personality Inventory (Sue & Sue, 1974). Kuo and Tsai (1986) also conducted a study that found that Asian Americans had higher average scores than White Americans on the Epidemiological Studies Depression Scale (Kuo & Tsai, 1986). With regards to the rate of suicide, Chinese Americans and Japanese Americans were found to have lower rates of suicide than European Americans when investigating age groups under the age of 64 years old. Chinese Americans over the age of 64 years old and Japanese Americans over the age of 74 years old have higher rates of suicide than their European counterparts (Yu, Chang, Liu & Fernandez, 1989).

Within the Asian American Diaspora, the need for special attention toward the mental health needs of Southeast Asian refugees require special attention. This is particularly due to the exposure to war trauma and political turmoil, including “torture, psychological and physical trauma, separation, and loss of family members” (Lee, 1997,

p. 7). Furthermore, Southeast Asian refugees have exhibited a wide range of disorders, including “posttraumatic stress disorder, dissociative disorders, organic brain syndromes, schizophrenia, conversion disorders, and paranoia” (Uba, 1994).

Culture-bound syndromes are certain illnesses prevalent in different parts of Asia that are known by their indigenous names, and are another area of special interest regarding the mental health needs of Asian Americans. Some of these culture-bound syndromes include *amok* (Lee, 1997; Tompar-Tiu & Sustento-Seneriches, 1995) and *hwa-byung* (Lin, 1983; Prince, 1989). *Amok* is a culture-bound syndrome experienced by Filipinos that is described as a “sudden, unprovoked, or disproportionate outburst of wild rage in which a person brandishes a *bolo* (long Philippine knife) or other weapon and kills or maims every person or animal he or she meets while running around in a frenzy” (Tompar-Tiu & Sustento-Seneriches, 1995, p.82). *Hwa-byung* is a “suppressed anger syndrome” experienced by Koreans that is characterized by “sensations of constriction in the chest, palpitations, sensations of heat, flushing, headache, dysphoria, anxiety, irritability, and problems with concentration” (Lin, Prince in U.S. Department of Health & Human Services, 2001, p. 115). As Asian immigration to the United States continues to grow, the need for further research on such syndromes will be essential to understanding the mental health needs of new immigrants in particular.

Because of the diversity of this racial group, most researchers agree that it is imperative that more research be conducted on the AA/PI population, with priority given to investigations that focus on particular AA/PI groups (David & Okazaki, 2006; Nadal, 2004; U.S. Department of Health & Human Services, 2001). Furthermore, although previous studies have been informative, most of them have focused on Chinese

Americans, Japanese Americans, and Southeast Asians, with few studies that exist on the mental health needs of other large ethnic groups, including Filipino Americans (U.S. Department of Health & Human Services, 2001). Attention to ethnic or culture-specific research in mental health will further promote knowledge about factors that affect help-seeking behaviors for mental health services, as well as effective ethnic and culture-specific interventions and treatment response, resulting in greater service utilization and more positive mental health outcomes (U.S. Department of Health and Human Services, 2001).

#### *Mental Health Needs of Filipino Americans*

Filipinos are currently the second largest Asian American population in the United States (Reeves & Bennett, 2004) and Filipino immigration to the United States continues to grow. Additionally, Filipino Americans have been identified as one of the high-risk Asian American groups for mental disorders (Tompar-Tiu & Sustento-Seneriches, 1995). Despite the high-risk status for mental health disorders and the large numbers of Filipinos living in the United States, few studies investigating mental health needs or patterns of help-seeking behavior for mental health services among Filipino Americans exists (Sustento-Seneriches, 1995; U.S. Department of Health & Human Services, 2001). In fact, research focused on Filipino Americans in the field of psychology is sparse compared to other Asian Americans. According to David and Okazaki (2006):

A search in the PsychINFO database using the four largest Asian American ethnic groups as keywords revealed 675 published works for Chinese Americans, 366 for Japanese Americans, 282 for Korean Americans, and only 90 for Filipino Americans (retrieved on June 5, 2004). (David & Okazaki, 2006, p.6)

This further reflects the status of Filipinos as “forgotten Asian Americans” (Cordova, 1983) or the “invisible minorities” (Cimmarusti, 1996).

The limited body of existing literature concerning mental health issues facing Filipino Americans indicates that Filipino youth are a major cause of concern, since they have one of the highest rates of suicidal ideation and attempts in the United States (President’s Advisory Commission on Asian Americans and Pacific Islanders, 2001), and depression is more prevalent among this ethnic group than the U.S. general population (Tompar-Tiu & Sustento-Seneriches, 1995). Kevin Nadal, a Ph.D. Candidate for Counseling Psychology at Columbia University in New York, has been at the forefront of researching mental health needs of Filipino Americans, and his focus for research includes:

... the Pilipino American experience, particularly Pilipino American identity and community development. His “Pilipino American Identity Development Model” (2004) has paved the way for Pilipino American culturally competent services in education, psychology, and health.  
([www.columbia.edu/~kln2005/mainframe.html](http://www.columbia.edu/~kln2005/mainframe.html))

Furthermore, Nadal’s “Pilipino American Identity Development Model” is a seminal work in which Nadal identifies that high rates of eating disorders, unintended pregnancies, sexually transmitted infections, and drug use among Filipino Americans have been reported but cannot be commented on due to the lack of research conducted specifically on Filipino Americans (Nadal, 2000).

### *Filipino Immigration to the United States*

Filipinos first arrived in the United States in 1587, when a Spanish galleon entered Morro Bay in California (Pido, 1997). Despite Filipinos’ early history in what

would later become the United States, it would not be until the late 1760's that the first Filipino settlement would be established in the United States, becoming the first wave of Filipino immigration to the U.S. These immigrants settled in the Louisiana bayous and were known as "Louisiana Manilamen" (Nimagadda & Balgopal, 2000; Pido, 1997; Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995).

The second wave of Filipino immigration to the United States took place between 1906 and 1934, when Filipinos were recruited as farm workers to work the pineapple fields in Hawaii and various farms on the West Coast. Derogatorily nicknamed "pineapples" or "little brown monkeys," second wave immigrants were mostly single young men between the ages of 14-29 years old who were uneducated or poorly educated and came from rural areas in the Philippines (Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995). These single men were not legally able to marry Caucasian women, and those men who were married left their wives and children in the Philippines, creating a tremendous sex imbalance of Filipino men and women. By the end of this immigration period, the Philippines had changed from a United States territory to a commonwealth as a result of the Tydings-McDuffie Act in 1934. This act changed the status of Filipinos to aliens instead of nationals and halted the annual quota of Filipino immigrants to fifty per year (Tompar-Tiu & Sustento-Seneriches, 1995).

Limited by the Tydings-McDuffie Act, the next wave of Filipino immigration to the United States was not until 1945. This wave lasted for twenty years and consisted mostly of servicemen, war veterans, military personnel and their families, who had fought with the Americans during World War II. Doctors, nurses, engineers, technicians, accountants, and students also immigrated to the United States during this period,

beginning the “brain drain” where highly educated people were leaving their poor native countries for wealthier countries abroad (Tompar-Tiu & Sustento-Seneriches, 1995).

The fourth wave of Filipino immigration to the United States began in 1965 with the abolition of the quota system instituted by the Tydings-McDuffie Act, and continues to this day. In the 1960s, doctors, nurses, and engineers came for better employment and further training. During the 1970s and 1980s, the Filipino American population increased by 113% due to political oppression and declining economic and financial conditions in the Philippines under President Marcos (Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995). At the turn of the century, over two-thirds of Filipinos living in the United States are foreign-born Filipinos, with 31.3% entering the United States before 1980, 33% entering the United States during the 1980s, and 35.6% entering the United States between 1990 and 2000 (Reeves & Bennett, 2000).

Currently, the vast majority of Filipinos living in the United States today are first-generation Americans, and have been dealing with cultural transition, acculturation, and the accompanying difficulties (Lee, 1997). In addition to these struggles, certain cultural traits of Filipinos (e.g. family closeness) that have been useful in the face of adversity can also potentially create psychological and emotional difficulties during the process of acculturation. Tompar-Tiu and Sustento-Seneriches (1995) give the following examples:

Extreme family orientation creates an in-group attitude that prevents family members from expanding their social interactions. This impedes their acculturation and prevents them from establishing alternative social supports in case the family disintegrates or the family members who provide the usual support are absent. ... In other cases, to have the feeling of belonging, people too used to having family support may be driven to join pseudofamilies, like gangs, when their own families break down. Excessive concern for the family’s image and reputation may also prevent the timely treatment of family members with mental disorders. The family may refuse to ask for professional help because of

the stigma associated with mental disorders and its effects on the prospects of the whole family. (1995, p. 122)

A further discussion regarding Filipino cultural values will be discussed in the literature.

### *Colonial Mentality*

In the discourse of Filipino American mental health, it has been widely accepted by researchers that Colonial Mentality is central to understanding the psychology of contemporary Filipino Americans (David & Okazaki, 2006; Tompar-Tiu & Sustento-Seneriches, 1995) and can “potentially explain the high rates of mental health problems among Filipino Americans” (David & Okazaki, 2006, p.241). Colonial mentality (CM) refers to a specific form of internalized oppression following colonialism, where Filipinos internalized an inferior status compared to their colonizers and embraced Western standards of beauty, goods, and culture as superior to their own (Tompar-Tiu & Sustento-Seneriches, 1995).

Spain was the first to colonize the Philippines, beginning with the arrival of Magellan to the Philippines in 1521, who claimed the islands for Spain. The Philippines remained under Spanish rule until 1898, during which time colonized Filipinos experienced “exploitation, brutality, cheating, cruelty, injustice, and tyranny,” and “native Filipinos’ indigenous culture and beliefs were replaced by Spanish culture and the Catholic religion” (David & Okazaki, 2006, p.7). Despite the violence and oppression experienced by native Filipinos, contemporary Filipinos and Filipino Americans have accepted the dominant view of the conquest, the “Golden Legend” that the Spanish risked their lives to bring the gifts of Spanish culture and religion to the uncivilized Filipinos, as the natural cost of progress (Rimonte, 1997). To show reciprocity for these gifts,



Filipinos hold a deferential gratitude towards the West, in which the Golden Legend is “so pervasive and so persistent... that anyone growing up in the Philippines breathes it with the air itself” (Rimonte, 1997, p.40).

The Philippines remained under Spanish rule until 1896, when a national Filipino revolution led by Andres Bonifacio ended Spanish rule after more than three hundred years of colonization. As a result, Spain sold the Philippines to the United States for \$20 million after the Spanish-American War. The U.S. colonization of the Philippines would last until the Philippines was finally able to declare independence in 1946 (David & Okazaki, 2006; Tompar-Tiu & Sustento-Seneriches, 1995). During this period of U.S. colonization of the Philippines, Americans established a nationwide public school system where most of the educators were American schoolteachers known as Thomasites (David & Okazaki, 2006; Tompar-Tiu & Sustento-Seneriches, 1995). Although this free education system was a positive change because it offered educational opportunities to Filipinos who could not otherwise afford it, some of the major drawbacks included “inculcating Pilipinos with American values” (Pido, 1997, p.24), English language, and shaping Filipinos’ worldview according to American views and political ideals (David & Okazaki, 2006). Furthermore, the Thomasites portrayed America as “the land of milk and honey,” which was especially appealing to Filipinos because many of them were poor and socioeconomic mobility in the Philippines was extremely limited at the time (Pido, 1997). Tompar-Tiu and Sustento-Seneriches (1995) argue that Filipinos “embraced the American culture and language and imitated the Western way of life at the expense of their own cultural and national identities... fostering the ‘Filipino dream’— emigration to the United States, in search of better opportunities” (p.6).

Colonial Mentality continues to be present among modern-day Filipinos and Filipino Americans as a legacy of more than four hundred years of colonization under Spain and the United States. In a study conducted by David and Okazaki (2006), the researchers argue that although CM may be manifested in a variety of ways, some common manifestations of CM include:

1. denigration of the Filipino self through feelings of inferiority, shame, embarrassment, resentment, or self-hate about being a person of Filipino heritage;
2. denigration of the Filipino culture or body through the perception that anything Filipino is inferior to anything White, European, or American;
3. discriminating against less-Americanized Filipinos (to distance oneself from the inferior characteristics attached to being Filipino and become as American as possible); and
4. tolerating historical and contemporary oppression of Filipinos and Filipino Americans (because such oppression is accepted as the appropriate cost of civilization). (David & Okazaki, 2006, pp. 241-242)

To explore potential psychological implications of CM on Filipino Americans, the researchers developed an exploratory research design that utilizes quantitative data to measure three general types of effects of colonialism: covert, overt, and colonial debt. Covert manifestations of CM (CMCM) describes the phenomenon where the colonized internalizes feelings of inferiority from external forces that are imposed by the colonizer. Overt manifestations of CM (OMCM) explain a phenomenon contrary to CMCM, where the colonized is driven by internal factors such as the desire to distance themselves from a perceived inferior identity. The third type of effect of colonialism has been described by Rimonte (1997) as colonial debt, where the violence and oppression of the conquest of indigenous Filipinos has been normalized or minimized as the natural cost of progress.

The researchers hypothesized that CM is a possible factor for low Collective Self-Esteem (CSE) and CSE influences mental health. Thus, CM likely affects the mental health of Filipino Americans and could potential explain the high rates of depression among this population. The researchers also hypothesized that CM affects acculturation, particularly the acculturation strategies of marginalization (low identification with dominant and heritage cultures) and assimilation (high identification with dominant culture and low identification with heritage culture) because both of these strategies are negatively linked to psychological well-being, and because CM is thought to increase the possibility of marginalization or assimilation (David & Okazaki, 2006).

Recruitment and administration of Filipino American participants for this study took place via Internet. Six hundred and three (603) participants completed the survey. Of these, 52% were from the West Coast and 66% were women. Instruments for measuring included the Colonial Mentality Scale-Initial (CMS-I), the Collective Self-Esteem Scale (CSES), the Vancouver Index of Acculturation (VIA), the Rosenberg Self-Esteem Scale (RSES), the Center for Epidemiological Studies-Depression Scale (CES-D), Exposure Vignettes, and a Schedule of Racist Events.

Various comparisons in this study were done using the different instruments for measuring (above). In regards to CM's effect on depression, it had a 1.7% variance. The researchers concluded that CM negatively affects the mental health of Filipino Americans, and that CM is passed on to future generations through socialization and continued oppression. Specifically, CM is manifested by Filipino Americans through internalized ethnic/cultural inferiority, cultural shame and embarrassment, within-group discrimination, physical characteristics, and colonial debt (David & Okazaki, 2006).

The study conducted by David and Okazaki (2006) made several contributions in the understanding of the effects of CM on the psychological experiences of Filipino Americans. However, the lack of empirical studies that investigate the relationship between CM and the psychological experiences of Filipino Americans, along with the fact that the development of a CM assessment scale was only recently developed by David and Okazaki (2006), make it difficult to determine any possible effects that CM may have on low mental health service utilization for depression and other mental health issues among Filipino Americans. However, the researchers were able to find evidence from this study that CM “is passed on to later generations through socialization and continued oppression that it negatively affects the mental health of modern day Filipino Americans” (David & Okazaki, 2006, p. 251).

#### *Indigenous Filipino Beliefs of Illness & Help-Seeking Behavior*

Indigenous Filipino beliefs about the causes of illness have been described as mystical, personalistic, and naturalistic beliefs (Tompar-Tiu & Sustento-Seneriches, 1995). Mystical beliefs attribute illness as a direct result of a behavior or experience of the victim that would result in retribution from God, the elders, or dead ancestors. Personalistic beliefs, on the other hand, attribute illness to supernatural beings such as ghosts, spirits, souls of the dead, witches, or sorcerers. Finally, naturalistic beliefs attribute illness to environmental elements such as cold, heat, thunder, lightning, diet, and stress. Although these indigenous beliefs about the causes of illness are likely to be more prevalent in the Philippines, these beliefs do not necessarily change upon immigration to

the United States, and may continue to exist, perhaps to a lesser degree, among Filipinos living in the United States (Edman & Johnson, 1999).

Western treatment of mental illness in the Philippines has been limited, which is largely due to poor economic conditions, political upheaval, natural disasters, and the archipelago geography, which affects transportation and communication of information and services. These factors have resulted in a lack of resources to sustain a more large-scale and systemic approach to treating mental illnesses. Given the indigenous beliefs of the causes of mental illness, and the general unfamiliarity of mental health and psychiatry as a discipline, Filipinos in the United States tend to turn towards indigenous methods of healing and seek mental health services only as a last resort, usually in times of crisis. As stated by Tompar-Tiu and Sustento-Seneriches (1995):

Filipino psychiatric patients have more confidence in the help of their families, their churches, their family doctors... than in the help available from mental health clinics... they still seek the advice of their priests for exorcism, their saints for healing intercessions, their traditional healers for rituals, incantations, and herbs, and their God- chosen healers who go into religious trances. (1995, p.71)

#### *Cultural Belief Factors*

In addition to the strong indigenous beliefs about the causes and treatments of mental illness, other cultural characteristics strongly influence Filipinos' willingness to seek mental health treatment. Some of the major cultural characteristics that affect Filipino behavior include *kapwa* (Nadal, 2004), *bahala na* (Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995), *hiya*, *amor propio*, *pakikisama*, and *utang na loob* (Gong et al., 2003; Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995).

*Kapwa* refers to fellow being and is “at the core of the Filipino personality” (Nadal, 2004, p. 50). As such, *kapwa* expresses unity between self and others as one being (Nadal, 2004). The concept of *bahala na* (“Leave it to God” or “Come what may”) refers to “passive acceptance of one’s fate, or to determination in the face of uncertainty” (Tompar-Tiu & Sustento-Seneriches, 1995, p. 120). It also refers to acceptance of uncontrollable situations, faith in God, and determination to persevere through events that are beyond their control (Tompar-Tiu & Sustento-Seneriches, 1995).

*Hiya* refers to shame, propriety, loss of face, or fear of losing face (Gong et al., 2003; Nadal, 2004; Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches, 1995) and can have a positive or negative effect on behavior (Gong et al., 2003). Nadal describes *hiya* as the desire of Filipinos to “represent himself or herself and his or her family in the most honorable way possible” (2004, p. 50), while Tompar-Tiu and Sustento-Seneriches refer to *hiya* as a “form of social control” that “signifies embarrassment and inferiority more than the occasional sense of guilt or failure” (Tompar-Tiu & Sustento-Seneriches, 1995, pp. 118-119). Nadal also mentions that for Filipinos, the avoidance of *hiya* may contribute to the inability to recognize mental or emotional problems (Nadal, 2004).

*Amor propio* is another aspect of face and is defined as self-esteem or self-love and can also have positive or negative effects on behavior (Gong et al., 2003). Tompar-Tiu and Sustento-Seneriches further describe *amor propio* as “great sensitivity to any personal affront that results in narcissistic wounding, particularly to lack of recognition of one’s social status and family standing” as “socially prominent people, figures of authority, and elderly expect and receive deference” (1995, p. 119). Tagalog language

also reflects the emphasis of recognition and respect of elders as the older brother and older sister are called *kuya* and *ate*, and *ho* and *po* are used in every sentence to address older family members (Sustento-Seneriches, 1997).

*Pakikisama* refers to social acceptance and getting along with other members of the group or community (Gong et al., 2003; Nadal, 2004). It also emphasizes achievement of status and power and the desire to be both socially accepted and socially celebrated (Nadal, 2004).

*Utang na loob* is one of the most important cultural traits among Filipinos and refers to an eternal debt of gratitude or reciprocal obligations and expectations towards family members based on unsolicited services (Sustento-Seneriches, 1997; Tompar-Tiu & Sustento-Seneriches 1995). This concept is so binding among Filipinos that even after the death of the person with *utang na loob*, “that person’s children and other relatives may continue to help pay back the favors” (Tompar-Tiu & Sustento-Seneriches, 1995, p. 119). This attitude reinforces the closeness of family and community members (Sustento-Seneriches, 1997).

Given this cultural context, Filipino culture seems to prioritize and reward family devotion and social harmony while de-emphasizing the importance of the individual, a viewpoint contrary to Westernized cultures’ emphasis on the individual. While these values remain intact in the native country, immigration to the United States and the challenges of adjustment and acculturation to American society often creates conflict between indigenous cultural values and values present in the host country. In learning to negotiate cultural differences between heritage culture and dominant culture, a struggle of transnationalism is often the result.

### *Conflicts Between Filipino and American Cultural Beliefs and Values*

Wolf describes transnationalism as “the notion of differing codes, cultures, ideologies and goals that circulate in the lives and minds of children of Filipino immigrants” (Wolf, 1997, p. 459). In a study of Filipinos students at the University of California at Davis, Wolf (1997) explored the effects of transnationalism on Filipino Americans during the 1995-1996 academic year. This study consisted of four males and eighteen females who participated in four focus groups. All of the students were either born in the United States or emigrated from the Philippines at an early age “before most of their childhood socialization or schooling occurred” (Wolf, 1997, p.461). Some of the themes discussed in the focus group included what it meant to be Filipino, parental pressures to achieve good grades and to pursue degrees that would lead to a job or graduate degree in a field chosen by parents, educational ambivalence, parent-child communications, cultural beliefs/practices that all problems should be kept in the family, family secrets, and thoughts of suicide.

The continuing struggle of transnationalism among the children of Filipino immigrants provides further insight into adaptation theory, which focuses primarily on four outcomes: “assimilation, integration, separation, and marginalization” (as cited in Ross-Sheriff, 1992, p.48). According to the researcher, “Although Filipino immigrant youth appear to be ‘assimilated’ in form, many are not reflecting the adaptation and acceptance that this concept implies” (Wolf, 1997, p.476). The result is that Filipino youth negotiate between “parents’ points of reference, their own hyphenated and hybrid identity, and what they view, perceive, and experience to be American and Filipino” (Wolf, 1997, p.475).



### *Coping and Help-Seeking Behaviors Among Filipinos*

Gong, Gage, and Tacata (2003) explored help-seeking behaviors among Filipino Americans, and how behavior is affected by face (*hiya & amor propio, pakikisama, utang na loob*) and language. In this study, Gong et al. utilized data from the Filipino American Epidemiological Study (FACES), a survey conducted in San Francisco and Honolulu between 1998-1999. The survey's probability sample of Filipino American households generally represents the Filipino American population that live in those areas.

Demographics include the following: 51% of respondents were female and 49% were male, the mean age of the sample was 42 years old, and respondents reported an average education level of 12 years (approximately less than a high school degree). The final sample size was 2,109 respondents and the response rate was 78%.

Instruments for measuring consisted of interviews that were conducted in English, Tagalog, or Ilocano, depending on the respondent's language of preference. Eligible respondents were Filipino Americans ages 18-65, who live in San Francisco or Honolulu. One eligible person within eligible households was randomly selected for the interview. Using Kleinman's typology (Kleinman in Gong et al., 2003), health care systems were divided into lay, folk, and professional sectors. Lay systems were defined as seeking help from a friend or relative, while folk systems were defined as seeking help from a priest, minister, spiritualist, herbalist, or fortune-teller. Professional sectors were further divided into mental health specialty care and general medical sector (Gong et al., 2003). Variables previously used to predict help-seeking behaviors in previous research were also incorporated and include mental health status, medical insurance coverage, and demographic controls (Gong et al., 2003).

Based on this study, researchers found that 75% of respondents have not used any type of mental health care. Among those who did seek help, 13% used the lay system only and 4% used the general medical sector. Among the four types of health sectors, the lay system was most frequently used (17%), followed by the general medical sector (7%), then folk system (4%), and finally the mental health specialty sector (3%). In regards to language, mono-English and bilingual speakers were less likely to rely on the lay system than those who are mono-Filipino speakers when dealing with health problems, but were more likely to choose mental health services or general medical services than mono-Filipino speakers.

Findings for this study concluded that (1) concern for face is negatively associated with help-seeking in formal sectors (mental health, general medical sectors) and is positively associated with help-seeking in informal sectors (lay, folk sectors); (2) Bilingual respondents and English speakers are more likely to seek care from formal sectors for emotional problems than monolingual Filipino respondents; (3) The effect of concern for face is lower among bilingual and monolingual English speakers but stronger among monolingual Filipino speakers (Gong et al., 2003). These conclusions were in agreement with all of the researchers' hypotheses and were consistent with the results.

Methods of coping among Filipino Americans has also been explored by Abe-Kim, Gong, and Takeuchi (2004) and Bjorck, Cuthbertson, Thurman, and Lee (2001). In the study conducted by Abe-Kim et al. (2004), religiosity, spirituality, and help-seeking was investigated, with particular interest in determining if there was any relationship between help-seeking from religious clergy and help-seeking from mental health professionals. This study was conducted using the FACES sample and found that rates of

help-seeking from religious clergy were comparable to rates of help-seeking through mental health professionals (2.5% versus 2.9%), and that high religiosity was partially associated with more help-seeking from religious clergy but not associated with less help-seeking from mental health professionals (Abe-Kim, Gong, & Takeuchi, 2004).

Bjorck et al. (2001) also investigated coping and distress among Filipino Americans, with comparison to Korean Americans and Caucasian Americans. In this study, the sample was collected from predominantly Korean American, Filipino American, and Caucasian American Protestant churches. Participants were asked to complete a questionnaire exploring interrelationships between coping appraisals, coping behaviors, and distress among each ethnic group. The sample was comprised of 228 participants, 49 of which were Filipino Americans, compared to 86 Caucasian Americans and 93 Korean Americans. This study revealed that Filipinos reported the use of passive coping behaviors such as accepting responsibility, religious coping, distancing, and escape-avoidance. This finding was similar to those of the Korean Americans but greater than the Caucasian Americans. In addition, Filipinos were found to report more use of problem-solving strategies, e.g. “attempting to solve the problem or change the stressor” (Bjorck et al., 2001, p. 436) than the other ethnic groups.

#### *Filipino American Identity Development Model*

This six-stage model was created by Nadal in order to better understand “the acculturation levels of the F/Filipino Americans, for more accurate and appropriate therapeutic or psychological practice” (Nadal, 2004, p.52). Furthermore, this model describes the process of ethnic identity formation for native-born/second-generation

Filipino Americans in the United States. This model is meant to be nonlinear and nonsequential, and will not be completed by every Filipino American (Nadal, 2004). Because these stages reflect the identity and experience of second-generation Filipino Americans, none of these stages should be seen as negative or positive but as reflective of the experiences of native-born Filipino Americans. In addition to furthering knowledge of appropriate therapeutic practice for Filipino Americans, this article has also been used as a basis for “Pilipino American culturally competent services in education, psychology, and health” ([www.columbia.edu/~kln2005/mainframe.html](http://www.columbia.edu/~kln2005/mainframe.html)).

Nadal’s Pilipino American Identity Development Model includes: (1) Ethnic awareness; (2) Assimilation to dominant culture; (3) Awakening to social political consciousness; (4) Panethnic Asian American consciousness; (5) Ethnocentric consciousness; and (6) Incorporation (Nadal, 2004). During each stage of development, five different attitudes and beliefs are assessed, including (a) Attitudes and beliefs toward self; (b) Attitudes and beliefs toward other F/Pilipino Americans; (c) Attitudes and beliefs toward Asian Americans; (d) Attitudes and beliefs toward other minority groups; and (e) Attitudes and beliefs toward White/dominant group.

Stage One, the Ethnic Awareness stage occurs during a child’s earliest memories, usually between the ages of 2-5 years old. During this stage, (a) Attitudes and beliefs towards self are positive or neutral because the child is happy to be him- or herself; (b) Attitudes and beliefs towards other F/Pilipino Americans are positive or neutral because they are the only noticeable group around the child; (c) Attitudes and beliefs toward Asian Americans are neutral because the child has a minimal concept of race or ethnicity; (d) Attitudes and beliefs towards other minority groups are also neutral because the child

has a minimal concept of race and ethnicity; and (e) Attitudes and beliefs toward White/dominant group are positive or neutral because of exposure to the dominant group through television and books.

Stage Two, the Assimilation to Dominant Culture stage, can take place as early as 5 years old and can continue for a person's entire adult life. In this stage, (a) Attitudes and beliefs towards self are negative or self-deprecating, including the denial or desire to change physical characteristics, or the feeling of embarrassment or shame regarding cultural values and traditions; (b) Attitudes and beliefs towards other F/Pilipino Americans are negative and group deprecating, and F/Pilipinos will internalize stereotypes and beliefs of the dominant culture, about him/herself and other minority groups; (c) Attitudes and beliefs toward Asian Americans are negative or group deprecating because the same beliefs about his or her ethnic group will be held towards Asian Americans; (d) Attitudes and beliefs towards other minority groups are negative or discriminatory because the internalization and adaptation of the dominant groups' beliefs creates a desire to reject any affiliation to any minority group; and (e) Attitudes and beliefs toward White/dominant group are positive or group appreciating because of the belief that the White race is superior and standard.

Stage Three, the Social Political Awakening stage, takes place when the Filipino or Filipina "begins to realize the social injustice and racial inequality of the world around him or her" (Nadal, 2004, p.55). During this stage, (a) Attitudes and beliefs towards self are positive or self-empowering due to the feeling of a sense of community involvement and a call to duty; (b) Attitudes and beliefs towards other F/Pilipino Americans are positive and group empowering due to the feeling of the need to encourage others of the

same ethnic group to feel the same way he or she feels; (c) Attitudes and beliefs toward Asian Americans are positive or group appreciating due to the formation of allegiances with other Asian Americans; (d) Attitudes and beliefs towards other minority groups are positive or accepting due to the desire to seek out other individuals who have been oppressed; and (e) Attitudes and beliefs toward White/dominant group are negative or discriminatory due to feelings of anger toward the notion of superiority of White culture in society.

Stage Four, the Panethnic Asian American Consciousness stage is unique to Filipinos because in this stage, F/Pilipinos will “take ownership of themselves as ‘Asian’” (Nadal, 2004, p. 56) in attempt to find similarity and power in numbers through Asian American social and community groups. During this stage, (a) Attitudes and beliefs towards self are positive because the F/Pilipino sees him or herself as part of the greater Panethnic group; (b) Attitudes and beliefs towards other F/Pilipino Americans are positive and accepting by understanding his or her role in a “centralized ‘Asian’ sense” (Nadal, 2004, p. 57); (c) Attitudes and beliefs toward Asian Americans are positive or group appreciating, which comes from pride in being an Asian American; (d) Attitudes and beliefs towards other minority groups are positive or accepting but the individual F/Pilipino will direct more of his or her compassion towards other Asian Americans; and (e) Attitudes and beliefs toward White/dominant group are negative or discriminatory due to feelings of anger toward the notion of superiority of White culture in society.

Stage Five, the Ethnocentric Realization stage, is also distinctly unique to F/Pilipinos because it is triggered by an event that helps the Filipino or Filipina “understand that he or she has been unjustly classified in the Asian American paradigm”

due to the awareness “of the marginalization of pinoys [Filipinos] or pinays [Filipinas] as Asian Americans” (Nadal, 2004, p.57). In this stage, (a) Attitudes and beliefs towards self are positive or self-empowering due to the desire to specifically advocate for the needs of his or her F/Pilipino people; (b) Attitudes and beliefs towards other F/Pilipino Americans are positive and group empowering due to the desire for other Filipinos to reach this stage too; (c) Attitudes and beliefs toward Asian Americans are neutral or group deprecating depending on the event that triggered this stage; (d) Attitudes and beliefs towards other minority groups are positive or group empowering due to the possibility of a negative outlook towards Asian Americans that will promote a desire to establish closer bonds with other minority groups; and (e) Attitudes and beliefs toward White/dominant group are negative or tolerant due to the preoccupation with trying to be recognized as a people, which results in a loss of energy to be discriminatory towards other groups.

Finally, in Stage Six, the Incorporation Stage, F/Pilipinos will be most satisfied with his or her culture but will be able to appreciate all other racial backgrounds as well. In this stage, (a) Attitudes and beliefs towards self are self-appreciating due to an appreciation of the different stages he or she has had to move through to get to this stage; (b) Attitudes and beliefs towards other F/Pilipino Americans are group-appreciating, including acceptance and support for all group members, regardless of their stage of identity development; (c) Attitudes and beliefs toward Asian Americans are accepting, but will differ depending on the triggering event that took place in Stage 4 and Stage 5; (d) Attitudes and beliefs towards other minority groups are positive or accepting due to the desire to seek out other individuals who have been oppressed; and (e) Attitudes and

beliefs toward White/dominant group include a selective appreciation for whom he or she can trust in the dominant group.

### *Summary*

The review of the literature indicates a growing need for Filipino American-specific research, particularly because of their unique historical and cultural characteristics, as well as the increasing number of Filipinos in the United States. While some exploratory work on the help-seeking behavior of Filipino Americans has been done, most of this work has been quantitative. Thus, we know little about help-seeking behavior for mental health services among Filipino Americans that is in their own voice. Because of the high-risk status for mental health disorders, coupled with the increasing rate of immigration to the United States, further exploration into help-seeking behaviors for mental health services among Filipino Americans, in their own voice, is all the more urgent.



## CHAPTER III

### METHODOLOGY

The purpose of this qualitative study was to explore help-seeking behaviors for mental health services among Filipino Americans. Filipinos are now the second largest Asian American population in the United States and Filipino immigration to the United States continues to grow. Filipino Americans have also been identified as one of the high-risk Asian American groups for mental disorders, yet as a population they remain understudied and underserved. Thus the need to know more about what factors determine help-seeking for mental health services among Filipino Americans is all the more urgent.

This study involved face-to-face interviews with a sample of convenience comprised of 12 persons of Filipino ancestry currently living in the United States. The interview schedule began with more structured questions that ascertained demographic background data and was followed by a series of more open-ended questions that explored factors that determined respondents' help-seeking behaviors for mental health services. The interviews were transcribed by this researcher and analyzed for recurrent themes.

#### *Characteristics of the Study Population*

To participate in this study, one had to be a person of Filipino ancestry (mono-racial, bi-racial, or multi-racial) currently living in the United States, fluent in English

and over the age of 18 years. As a matter of convenience, the sample was drawn from the San Francisco Bay Area where this researcher was placed.

### *Recruitment*

This researcher adopted a snowball sampling strategy to recruit the sample. Friends, family members, and colleagues were solicited and asked to help identify Filipinos they knew that might be potential candidates for the study. Filipino student organizations at colleges and universities in the area, various community centers/groups, religious groups and professional organizations in the San Francisco Bay Area that focused on Filipino populations were also solicited. This researcher also advertised the need for participants for this study through public postings located on college and university campuses in the area. Initial contact with each group varied, but may have included communications via mail, email, phone, or in person. As the names and contact information for potential candidates became available, they were sent a recruitment letter introducing this researcher and study, and a copy of the Informed Consent form. This was followed up by a telephone call from this researcher to clarify any questions and to schedule an interview with those who agreed to participate.

### *Nature of Participation*

Those who agreed to participate in the study were seen in a face-to-face interview. The interview was scheduled at a time and place that was convenient for both the participant and the researcher. The interview schedule began with structured questions that elicited demographic background data. This was followed by a series of semi-structured and more open-ended questions that explored respondents' help-seeking

behavior for mental health services. Participants were given the opportunity to ask any remaining questions about the study at the time of the interview and were required to sign the Informed Consent form before the interview proper began.

#### *Risks and Benefits of Participation*

There were few risks to participants anticipated with this study. Participation in the study was voluntary and participants had the right to refuse to answer any question(s) during the interview. They also had the right to withdraw from the study at any time before the findings were written up and any data they may have provided would have been destroyed. However, since it is always possible in any experience of self-reflection that strong feelings may be evoked that a participant might feel warrants further exploration, at the time of the interview each participant was given a list of mental health resources available in the community, should there be the need for this additional support.

Participants were informed that there were no material benefits to participating in the study. Participants may have benefited from knowing that they were contributing to the professional knowledge base of mental health practitioners that work with Filipino populations. They may also have benefited from having this opportunity to reflect upon and discuss their personal views and experiences. Each participant received a summary of the study.

#### *Informed Consent Procedures*

Participants were sent a copy of the Informed Consent form early in the recruitment process. This document described the purpose of the study, the nature of

participation being requested, anticipated risks and benefits, and their right to not answer any particular question(s) and to withdraw from the study without penalty at any time before April 1, 2007, when the results of the study were written up. It also made clear that the interview would be audio taped and that this researcher may be taking a few notes during the interview. Participants had the opportunity to ask questions about the study when initially contacted by phone, as well as at the beginning of the face-to-face interview. The Informed Consent was signed before the interview began, and all participants were given a copy of the Informed Consent for their records.

*Precautions Taken to Safeguard Confidentiality and Identifiable Information*

All names and other identifying information were removed from tapes, transcripts and notes and replaced by a numeric code. Information collected during the study was reported in aggregate form only. Any illustrations or brief quotations included in reports of the study were sufficiently disguised to prevent identification of specific subjects. Participants' signed Informed Consent forms were kept separate from the data collected. This researcher will keep all tapes, notes, and transcripts secured in a locked file for three years as stipulated by U.S. federal regulations, and will continue to maintain them secured until they are no longer needed. They will then be physically destroyed by this researcher.

## CHAPTER IV

### FINDINGS

#### *Demographics*

The sample was comprised of nine women and three men, ranging in age from 22-69 years old, with a mean age of 42 years old. Of the participants interviewed, seven (7 = 58.3%) were born in the Philippines and five (5 = 41.7%) were born in the United States. It is interesting to note that Philippine-born participants tended to be older. All except one were age 42 or older. In regards to year of immigration to the U.S., all of the Philippine-born participants immigrated to the U.S. during the last half of the twentieth century. Of these, six (6 = 50%) are now naturalized citizens and only one (1 = 8.3%) is not.

Places where participants lived, other than the United States and the Philippines, were also explored. Of the five American-born participants, all (5 = 41.7%) had only lived in the United States. Four of the Philippine-born participants (4 = 33.3%) had lived elsewhere other than the United States and the Philippines. These countries included Canada (2 = 16.7%), Scotland, and Japan. Three of the Philippine-born participants (3 = 25%) had not lived anywhere other than the United States and the Philippines.

In terms of highest level of education completed, all 12 participants were at least high school graduates and 11 of the 12 participants (91.7%) had also pursued education beyond high school. Of these eleven, nine participants (9 = 75%) completed a Bachelors

degree or more. Of the remaining two participants, one (1 = 8.3%) had attended some college and the other had completed an Associates Degree. The majority of these participants (9 = 75%) were educated in the United States. Of the remaining three participants, two (2 = 16.7%) were educated in the Philippines, and one (1 = 8.3%) was educated in Canada. Nine participants (9 = 75%) also indicated a school or career specialization. Professional occupations included engineering, laboratory technology, health professional, finance, and environmental consultation. This was a fairly affluent sample, and incomes for this sample tended to be bi-modal. Specifically, five (5 = 41.7%) had incomes between \$25,000 – \$50,000 and five (5 = 41.7%) had incomes over \$75,000. The remaining two participants (2 = 16.7%) had incomes in the \$50 – \$75,000 range. All three (3 = 25%) of the male participants were in the highest income group for this sample.

#### *Ancestry & Identity of Sample*

To participate in this study, one had to be a person of/with Filipino ancestry (mono-racial, bi-racial, and multi-racial) who is fluent in and able to read English, over the age of 18 years, and currently living in the United States. Of the 12 participants that comprised the sample, five reported their ancestry to be Filipino, and two reported that one grandparent was Chinese and the rest of their ancestry was Filipino. Other participants reported their ancestry to include: one parent who is Filipino of Spanish descent and the rest of their ancestry is Filipino, one parent of Filipino ancestry, one grandparent who is half Chinese and the rest of their ancestry is Filipino, one great-

Table 1

*Participant Demographics*

<u>Participant</u>	<u>Age</u>	<u>Born</u>	<u>Race/ Ethnicity</u>	<u>Age/Year Immigrated</u>	<u>U.S. Citizenship</u>
1	22	U.S.	Filipino American	N/A	Yes
2	25	U.S.	Mixed	N/A	Yes
3	28	Philippines	Filipino	10/1989	Yes
4	30	U.S.	Filipino	N/A	Yes
5	30	U.S.	Filipino	N/A	Yes
6	32	U.S.	Filipino	N/A	Yes
7	42	Philippines	Filipina	22/1987	Yes
8	42	Philippines	Mixed	33/1998	No
9	48	Philippines	Filipino	23/1982	Yes
10	66	Philippines	Filipino	47/1988	Yes
11	68	Philippines	Filipino	34/1973	Yes
12	69	Philippines	Filipino	21/1959	Yes

grandparent who was Spanish and the rest of their ancestry is Filipino, and one great-great-grandparent who has some Spanish ancestry and the rest is Filipino.

Participants were also asked to state how they identified racially and ethnically. Eight participants identified as Filipino, one identified as Filipina, one identified as Filipino American, one identified as “mixed,” and one identified as Filipino and Mexican.

Table 2

*Participant Demographics*

<u>Participant</u>	<u>Age</u>	<u>Education/ Location</u>	<u>Current Occupation</u>	<u>*Current Income Range</u>
1	22	Bachelors/U.S.	Consultant	B
2	25	High School/U.S.	Laboratory Technician	B
3	28	Some College/U.S.	Laboratory Technician	B
4	30	Some Masters/U.S.	Engineer	C
5	30	Masters/U.S.	Health Worker	B
6	32	Bachelors/U.S.	Engineer	D
7	42	College/U.S.	Finance	D
8	42	Masters/Philippines	Finance	B
9	48	Nursing/Canada	Nurse	D
10	66	Bachelors/U.S.	Consultant	C
11	68	Bachelors/Philippines	Engineer	D
12	69	Associates/U.S.	Retired	D

\*Note: Under \$25,000 = A; \$25,000-\$50,000 = B; \$50,000-\$75,000 = C; Over \$75,000 = D

*Knowledge of Mental Health Counseling*

When asked what participants knew about mental health counseling, the majority (11 = 91.7%) of them were familiar with some form of mental health counseling. It should be noted that three of these participants seemed to be put off with “mental health” and “counseling” being joined together, since they thought that “mental health



counseling” would be reserved for people who were “going crazy.” However, it became clear in their different comments that these three were conversant with other forms of mental health counseling for populations they considered as disturbed. One participant did not know anything about mental health counseling.

Participant #12

I know nothing about [mental health counseling]. ... Not even a reading about it. ... I don't know nothing about mental health as such. ... Yes, well, counseling, yeah... various degrees of counseling. ... When you say “mental health,” it sounds very general to me. ... The first thing that comes to your mind when you say the word “mental” is that you're going crazy. That's the first thing. But I guess it's not really that. ... [I've] heard of counseling for students in school, or grown-ups that have problems with relationships or psychiatrist problems or psychological problems. I guess they're kind of disturbed and cannot cope, and they go see a counselor. So that's what I think about counseling – somebody from the outside that helps somebody that struggles.

Participant #1

I think of mostly two types of counseling of whether it's psychiatry or psychology and either behavioral methods or medications. Most of the time I think of the people that I know that have gone to counseling or are thinking about it or have gone through it, most of the time because of depression or having trouble with grieving over loved ones. So that's mostly what I think about.

Participant #2

I don't really know that much, just that when people have problems or something they go to a psychiatrist. ... My experiences [with mental health counseling] are just, you know, you see it on T.V., “Dr. Phil,” and stuff like that.

Participant #11

It's not very prevalent, I think, use [of mental health counseling], among Filipinos. I'm not sure. I just heard, “You know, the son of so-and-so committed suicide.” Something like that. Or depression.

Participant #6

When I [first] think of mental health [counseling], I think the extreme of mental problems. But I think mental health [counseling]... it could be anything like [help dealing with] cancer or anything like that.

Participant #11

This is my first time [refers to when researcher first contacted participant about study] to hear about mental health counseling.

### *Views about Mental Health Counseling*

When asked about their views of mental health counseling, all participants (12 = 100%) indicated that they viewed mental health counseling positively. Responses ranged from seeing mental health counseling as a way to get help with problems, deal with a busy lifestyle, and as vital in addressing health needs that are both mental and otherwise.

#### Participant #6

I'm not sure if it cures everyone, or if it helps them. But it's something in the right direction, if people have the option of trying to help themselves [to] feel better about themselves. So I think it's a helpful thing for whatever problem they might have or issues they have.

#### Participant #4

So, how I feel about mental health [counseling] is that it's a good thing. I think it's really, really good, because the way the world is now, it's so tough to be a mom, be a full-time worker, be an employee, be a supervisor. It's so hard to play all these roles at one time.

#### Participant #8

I mean like, people sometimes need the space, without the fear of other people knowing what they have been keeping inside. Because it's so hard to keep a lot of things inside. I mean, there's a lot of garbage that you have to throw out. Or you'll explode. So you have to let it out, and that's a good thing.

#### Participant #3

I think it is vital because you need somebody who's objective, and who actually knows, who can pull apart. ... You know a lot of people I think are depressed don't know that they are. I know you see these all these commercials about medicines and stuff on T.V. before. Well, I feel all that stuff at one point in time, but that doesn't mean I'm depressed. I'm fine! That's why mental health professionals are necessary to do so, in order to determine whether or not you need medicine. Some doctors like to throw something at you so they won't have to deal with you, and I think a mental health professional is more of the one that sits and knows the right questions to ask, how you really are feeling, or if it's just "You don't get enough sunlight" or something like that. So you know, it could be various things; you may or may not need [medications]. Maybe you need an adjustment in your diet. ... So I mean, I think [mental health professionals] are really important so that way you can narrow it down and not take medicine unnecessarily or anything like that.

Participant #9

I suppose [mental health counseling is useful], if you really need it. ... I'm not really aware of what kinds [of services] are there either. ... We usually refer them to social workers, and they take it from there.

Participant #1

I think it's very useful. I don't think it's promoted enough in [the Filipino] community, because I think there's this stigma that, what goes on in the family stays in the family, and that we can just help ourselves. And I know – I think that's still something that's being broken. I don't think it's as bad as it was maybe 5 or 10 years ago. I think it's improving, but I think there's more room for improvement.

*Usefulness of Mental Health Counseling*

Participants were asked if they thought mental health counseling was useful.

While all participants indicated that they viewed mental health counseling to be useful, their opinions about the degree of usefulness and for whom varied. Participants' responses ranged from viewing mental health counseling as something useful for everyone (9 = 75%), to useful if really needed (2 = 16.7%), and/or useful for some people (1 = 8.3%). In contrast, one participant was clear that he did not find mental health counseling to be useful for himself, but considered it to be useful for others.

Participant #12

... as an individual, I don't think that I need it. Other people might have a different opinion. I want to handle it myself. I've always handled things myself. If I got a problem, I don't go outside, I just handle it myself. ... I don't go around shouting and doing all kinds of stuff, I just sit down and try to figure it out. ... Every day I see people that really do need help.

Participant #10

I think it's helpful, but there's still a stigma. Among Filipinos, [when] they [think] of mental health [counseling], it's probably, likely, "Oh my God, he's crazy." I think that's the word, crazy. ... I think education is important for our culture to understand what mental health [counseling] is all about. . .

Participant #8

Yeah [mental health counseling is useful], for some people. Like some told me they went to a counselor because they underwent difficult situations in life and also this lady from here, her husband died suddenly. So she went to the counselor at the time she was grieving. And then another lady, she had breast cancer. So she was able to recover, it wasn't really something that was fatal, but then she got kids to take care of, so she underwent counseling over it. And then I know of a guy who lost his job... so he underwent counseling.

Participant #3

Yes, if people need them. The only thing is that I think a lot of people don't know when they do need them. Some people are just tough, they kind of let it out or whatever, but I think a lot of people are scarred, from their childhood or whatever experiences, because they didn't talk to somebody who was there to talk and they figured, "I'll just gut it out."

*For whom and in what Situations is Mental Health Counseling Useful?*

Participants were also asked for whom and in what situations they thought mental health counseling would be useful. The most frequently mentioned need for mental health services (11 = 91.7%), was for situational stress associated with critical life transitions such as marriage, divorce, retirement, and having children. Participants also reported many different ideas that included all stages of the lifecycle and encompassed a full range of problems that included: people with a family history of mental illness; people with medical conditions and illness; people with drug addictions; "anybody;" children and teenagers; difficulties in marriage, family, and intimate partner relationships; parents; elderly, people who are open to counseling; and people without other forms of support.

Participant #12

Well, uh, nowadays, for some reason, our younger generation, younger people, high school students, uh, they have problems with, um, dealing with everyday life. Uh, even as much as dealing with their own parents or their own brothers and sisters or the family stuff, and then they result to drinking and drugs and sometimes stuff like that. ... Now, older people... beyond 70 years old... now they have different problems – seeing things or hearing things or very suspicious.

Uh, I hear a lot of older folks, I don't know if [it's] because of dementia or what, but they get suspicious of other people.

#### Participant #11

Like for those people who are having problems with drugs or... those people who experienced such a traumatic events in their lives. Like students in school where they have problems where somebody got killed or you hear in the newspapers that most students go to counseling after somebody was killed in their school. I heard that's a part of the mental health counseling.

#### Participant #10

Choosing a retirement between here and the Philippines could be. ... Like, I have a sister-in-law and her husband says, "Once I retire, I'm going back to the Philippines." And I was like, "What? He has a family here, and he'll retire over there? So what kind of arrangement is that?" You might as well have divorced each other. So what's the point of being married if the life in the Philippines is better than here and the wife doesn't want to go? And that would cause mental health [problems]. Because the wife is like, "I don't want to do the Philippines. I don't understand. I want to stay here." And so the wife would be depressed. ... Someone in the family had cancer or stroke. Taking care of the disabled and taking care of the parents – they don't want the dad to go to a care home, so sometimes they have to take turns taking care of the parents out of their love, or they say, "No, I don't want my mom or my dad to be taken cared of by the skilled nursing." So I think that could cause a depression. ... She could be depressed all along and not realize it because, [she's] like a superwoman, and that could resort to having a mental health [problem] or depression. One of these days you just snap, [thinking] "I don't want to take care of anyone anymore, I'm tired." So I think counseling would be helpful for anybody who is, who had gone through life taking care of sick parents or sick family members. You know Filipinos are very caring and very attentive to their loved ones. You're trying to do your best, but you could suffer from mental health [problems].

#### Participant #9

Well again, it depends on the situation but. ... It just depends. ... Off the top of my head, probably someone with – like a manic depressive disorder. We get that sometimes. But we refer them to the social worker. ... Like Schizophrenic maybe?

#### Participant #8

Children, especially teenagers. I think maybe they need to talk to someone other than their parents. ... I think especially in public high schools, they should have [counseling available] because there are a lot of things going on, and parents will always be the last one to know. ... Well parents themselves. Because they got to be busy, and other things that probably they just need to sit down and talk to someone and work things out. They got to be busy, involved with their work,

family life gets too overwhelming at times, especially here. ... Like I got a friend – she spends most of her time just driving around. Like she’s got two sons and one has to go to baseball, one has to go to karate, it’s full-time job! And she’s by herself. And she can hardly return my calls. ... People undergoing any type of crisis in life that they couldn’t handle on their own. Especially for people who don’t have any kin support background. I think religion is a big factor, like if you know how to pray, you may no longer need powers in counseling, because there’s someone where you can unburden. But religion is not only a big factor, it’s like a concern. A lot of people are what they call “non-practicing” whatever. Non-practicing Catholic, non-practicing Protestant or whatever religion you have, then they will go nuts because they don’t have a religion. So what’s going to happen to them? Like if they undergo some problem that they can’t handle? They need somebody to talk to...

### Participant #3

Women who just had babies. Every woman should be checked out for post-partum, I don’t care how happy you think you are.

### Participant #2

I think it’s helpful for not like the mentally ill or anything, but like people for like marriage counseling and stuff like that, and people that are addicts. I think it helps them more because then they realize what they’re doing wrong. It helps them get out, instead of just ignoring the issue and stuff. ... I don’t know about the other side that actually ha[s], like, more deeper issues...

## *Personal Experiences with Mental Health Counseling*

Half of the participants (6 = 50%) had experience with mental health counseling, and half had not. The initial presenting problem for seeking mental health treatment was equally divided between those who sought treatment for depression secondary to the end of an intimate partner relationship, and those who sought help for marital issues. It should be noted that three participants had multiple treatment experiences. One of these was sent for treatment during adolescence for being rebellious and not getting along with her family. This participant considered this a failed experience because she was forced to go and could not be open. Thus, this experience is not included in the data because she did not initiate it. However, she later sought treatment on her own for depression that

was secondary to the end of an intimate partner relationship and that experience is included. The second participant with multiple treatment experiences had three. The first was for depression that was secondary to the breakup of an intimate partner relationship during college. This experience is included in the data. The second was for depression that was secondary to the disengagement from parental ties during early adulthood when she was transitioning into marriage. And the third experience was for communication issues in marriage and the participant was seen in marital therapy. The third participant initially sought treatment around marital issues. This experience is included in the data. She later sought treatment a second time due to depression secondary to the breakup of an intimate partner relationship that took place after she had divorced her husband.

Participant #7

A few years ago, I was getting off of a relationship and I was under, I was kind of, I was very depressed, and I wasn't sure what to do, so, personally yes... I did do counseling.

Participant #6

Me and my wife had marriage issues... communication [issues] or something. ... It helped her open up; it helped me open up so we're feeling much better with each other.

Participant #5

I never really sought [mental health counseling] until I had to do my Masters program. Because I had something come up. I had a really bad breakup, and I went into a heavy depression, and that's when I actually sought therapy.

Participant #4

Okay, so for my, for the first [time I went to counseling], it was basically depression and anxiety. ... I got depressed when I was 22 when I lost a boyfriend and it felt like the whole world totally crumbled and everything. ... I totally broke down. And I stopped talking, I stopped eating for a little bit, I didn't want to talk to anybody. I really, really broke down. And it was at that point where I thought, "You know, I have to see somebody, I cannot handle this, and I need do something about this." So after going through this telling session with this person,

getting my feelings out to somebody who was not judging me, [or] making me feel like my problems were petty, you know it really helped. It really got me to this point of peace with myself. ... And for the marriage, it was mostly just marital friction. Not having, not being on the same page... the feeling of an unhappy marriage.

Participant #3

I was having really bad issues with my husband. He didn't believe in fidelity. So it was that type of counseling. I saw [my counselor] for probably – oh, I think it was probably for a few months. But you know, counseling can only do so much; you have to make the relationship work.

Participant #1

When I was in high school, the first time that I was exposed to counseling was because I was really rebellious and I was, um, I was not getting along with my family. ... I actually decided to go back to counseling on my own in college, because... I [couldn't] simplify all the things in my life that w[ere] going on at the time because my aunt died and then my grandma died and then I had this boyfriend and was in, like an emotionally abusive relationship. ... I think it's helpful for anyone, whether they are going through something really traumatic or if they're just really stressed out, I feel like it could help, because my counselor helped me with stress management, on top of... she's really just a sounding board for bouncing off ideas and helping me clarify where I want to go in my life, and I think for other people or other stages in my life where it was so depressing. ... I felt like at times like that, that [counseling] was really helpful in how do I keep myself above water.

*Length of Time Before Seeking Treatment*

Participants were also asked how long their issue or situation had been a problem before they decided to seek treatment. Length of time before seeking treatment varied among participants, and ranged from 2 weeks to 2 years. For those who sought treatment after the end of an intimate partner relationship, length of time before seeking treatment ranged from 2 weeks to 1 month.

Participant #5

We broke up in August and I think I sought treatment in late August...[so] probably like, a month.



Participant #4

The first time was probably 2 weeks, when I decided I needed help. ... The first time when I was totally by myself, and I had my parents and I thank, you know, thank God that I had them there with me, but because I felt so alone and nobody could understand what I was going [through], [or] what I was doing. I needed to get help. Because I was just having conversations in my head over, and over, and over. I was basically just self-destructing myself.

Participant #1

I think it probably took about a month. Because we had already broken up and it was a couple of weeks after we broke up and I, one thing is that I knew I didn't want to go through this breakup by myself because I knew I had to grieve and I knew I had to talk to someone about it. And at the same time I didn't want to talk to my girlfriends about it because they can be biased. And at the same time I didn't want to burden them with my problems. And so, that really pushed me to want to see a counselor.

For those who sought counseling for marital difficulties, length of time before seeking treatment ranged from 2 weeks to 2 years, with an average of 2 months before seeking treatment. This seemed to be influenced by the nature of the circumstances regarding the marital issues, and what was going on in each participant's life at the time.

Participant #7

The first time when I started thinking about divorce... [it took] maybe a couple of weeks.

Participant #6

I guess, probably a couple of months in my opinion before it actually came out and thought we should see [a counselor] – it built up, it didn't happen that day – it was obviously building up, [so] a couple of months.

Participant #4

The marriage, probably it took a good, maybe 4 to 5 months of not feeling happy, because, you know, when you're married and there's two people, you kind of have to – and you have your role of being mom, you have your schedule with your child, things like that, it's a lot easier to not – to ignore it. It's a lot easier to ignore it.

### Participant #3

Two years. ... When I first found out [about the infidelity], I was 8 months pregnant with my second son. That was tough. You know, I was like, "I'm going to leave!" – I can't leave! My oldest was 2 and I had a baby on the way...

### *Alternative Solutions to the Problem*

The six participants who had sought mental health counseling were asked what solutions to the problem they attempted prior to seeking mental health counseling. Three themes emerged, which included seeking support from significant others (3 = 50%); trying to change or fix the problem by dealing with it directly (2 = 33.3%); and prayer, church, or religion (1 = 16.7%).

### Participant #5

I never sought therapy because I always felt like, "I always have my sister." I always felt, like, she had been my therapist, I think. She's helped me, she knows why I left [the relationship], and she knows a lot of language from it. So I've always consulted her. I've never felt like I had to actually seek someone else... formally... because she already knew me, and I didn't want to have to start a new relationship.

### Participant #1

I kept surrounding myself with other people – not being alone. I think that really helped. Partying. ... Exercising. ... I think my parents really helped. I felt like I wasn't hiding anything and I was being honest and real with myself. And I was keeping myself busy. I was really – I was more focused than ever on school...

### Participant #3

[I thought] if I stayed home and took care of the children all the time, if I lost 30 pounds because I thought I'd look prettier for him, it didn't matter. He'd love that. But he'd still go out anyway. So it didn't matter. Definitely, it wasn't anything I could fix.

### Participant #6

We tried talking about the problems, sat down with each other, where we thought were problems, but you know, first we tried that but for us, we felt like we just fell in the same routines as before – we're still getting mad, maybe worse... so we finally got to the point where [we thought], "Let's just try [counseling]." Go in it with an open mind and see what happens.

#### Participant #4

And also God, going to church, finding this, you know, [feeling] like, “Let me deal with my problems somewhere else. Why am I carrying this burden?” You know, so I guess how I feel about having the religion – the religion background really helps. Feeling just that, you’re just human. You’re just going through the motions, but you know, there’s [more] out there for me. Or realizing there are plans for me, I’m just going through a rough patch right now. You know, you kind of realize the light at the end of the tunnel. ... And when I was going through what I went through with... my boyfriend at the time, when he left me... I really [sought] my inner spirit, you know, that God’s really there for me. And so I really used it... along with my counseling to become stronger emotionally.

#### *Factors Affecting the Decision to Seek Treatment*

Participants expressed many different reasons to seek treatment for their various problems, however, all (6 = 100%) sought treatment after they had exhausted their usual resources used to deal with problems, and felt that they were unable to deal with the problem without seeking the help of a mental health counselor. Specific reason for seeking treatment included: feeling a need for unbiased support; feeling like the problem had gotten progressively worse; drastic decline in functioning and feeling a loss of self; feeling a loss of control; needing alternative methods of support; and “hitting rock bottom.”

#### Participant #7

I wanted to get some unbiased opinions [about whether or not to divorce]. ... after talking to friends, it felt like I’m not getting what I need to hear. So I felt like I was getting a lot of sympathy, so I thought, you know, at that time that I’m just going to see a counselor.

#### Participant #6

We [would] try to see if something was wrong... because it wasn’t healthy for the kids. Like, “Let’s just try something because it’s not healthy for the kids”... or for ourselves. [We were] going through our everyday lives knowing that there’s something over our heads that we shoulder – just lashing out at each other.

#### Participant #5

It wasn't until... that breakup, when I was actually in [name omitted], where I knew I needed [counseling] because it totally catapulted me. ... I couldn't even recognize it. ... I felt very – like I lost my confidence and faith in my abilities and [was] very withdrawn, and I knew it wasn't me. ... I cried. ... my schoolwork was so hard. Everything just became... magnified in difficulty and intensified, like I felt like a shell or I had lost myself. And that's when I knew.

#### Participant #4

I got that that point where you feel like you're not in control anymore and I didn't like how I was feeling, and I knew that there was something that I could do. How am I going to better [myself]? How am I going to make me feel better? I have to go seek help, because I can't do it myself. My mom's not helping me because she just saying, "Oh, just eat. Oh, just forget about it." But that's not it! That's not going to solve the problem.

#### Participant #3

Because [the infidelities were] the third incident or the fourth incident, I just figured, it was a repetitive thing, and I kept staying, I kept forgiving – it happened again... he was repetitive in his mistakes, and by the time, by the fourth time, I thought I needed counseling because that's the only way I was able to stay with him back then. And when I did, it kind of helped me see perspectives of things. And I tried to change in order to be the person he wanted me to be.

#### Participant #1

I actually think it was reaching rock bottom. I was totally scared about it at first and I went to a friend that was actually studying to be a clinical psychologist. ... And she really helped me, at first she was really supportive and that helped me get kind of connected because I told her I'm starting to think about this and I think I might really need it. And she was really supportive of it, and was telling me her experiences. She admitted to me that she was going to it too and it was just helpful for her as a check-in basis, not necessarily that she had deep things to get into... and I was thinking, "Yeah, I could use both". ... And I think really just having that support and feeling like I had someone's hand to hold on to, to guide me into it was helpful, because I don't think I would have done it... I'm not sure if I would have done it, or felt like I could have done it if no one was there behind me.

### *Treatment Expectations*

Of the six participants that sought mental health counseling, five participants (5 = 41.7%) stated that treatment met their expectations, and one participant (1 = 8.3%) stated that they did not have any treatment expectations.

#### Participant #5

I think [my therapist] did, because, like, I knew I needed a lot of help, and by him talking through a lot of my issues, and actually recommending both CBT [Cognitive Behavioral Therapy] and medication, I think that the process around it, that was really helpful. And I always felt like, I don't know, when... because of schoolwork I was having a hard time focusing and all that stuff... I felt bad seeking help for like, extensions on papers or whatever. And I felt like I was using it like a crutch. I didn't want to... like I didn't want... to use that as a label, like being depressed or whatever and then how that would impact my studies. So he would just... he would always remind me, like when I would get depressed, "You are not operating at the same levels your peers are, so you definitely need assistance and it's okay for you to seek that." And I felt like every meeting we had, he always had to reinforce that.

#### Participant #4

Yeah. It did [meet my expectations] because you kind of feel this weight lifted off your shoulders because you've let all this go. Even though you didn't let it go completely, but you let it out through your mouth, kind of making you feel like, you know, you actually talked about and you actually are making an effort to try to get to the root of the problem. It helped.

#### Participant #1

... at first, yeah [it met my expectations]. Because I always felt good after therapy. I remember the first few months of therapy, I'm thinking of the first year, after every session I felt – I felt clean. Like I felt like everything was resolved. And the thing is now, I don't really talk about anything of substance, it makes sense that I don't have that. I don't have that effect afterwards. It's more of preventative right now.

#### Participant #3

I don't think I realized what treatment is. I don't think I followed through with it like I was supposed to, because there was always something else. Or maybe I was just too chicken-shit. I don't know. I saw [my therapist] consistently for a couple of months, and I was supposed to keep seeing him... until we had met this certain expectation. I never followed through with that... I just said, "Cancel all of [my appointments]. I don't want to deal with it." That's why it didn't work. I know I fucked up.

### *Conditions Under Which Participants Would Seek Treatment*

Participants were asked if they had any experience with mental health counseling. Six of participants (6 = 50%) in the sample had no experiences with mental health counseling. Of these, three participants (3 = 50%) indicated that they could not imagine any conditions under which they would seek counseling:

#### Participant #12

No, for the same reasons – I think I'll handle it myself. I'm not saying that I may never do it, but at this point I cannot see needing it. I deal with it. I deal with it and I don't go outside. I don't even ask my wife. I don't ask her. I'll deal with it myself. Any problem, whether it's a problem within the family, I'll deal with it myself. There's no guarantees that it's always right, but I'll deal with it myself.

#### Participant #11

Right now, I don't see anything that will require me to go to counseling. I don't think so. Right now, I don't think so.

#### Participant #5

Not at this time. Like I think I got out of it already. But then I – because then at that time I contemplated on taking – committing suicide. Not once, but a lot of times. So I think usually in those kind of situations, people should really consider seeking a counselor. ... On a personal level, like there's a portion of my life where I needed [a counselor], but then since my sister's a nun, also a psychologist, who was a psychology major and all that kind of thing, I didn't need one. Like, I have a church I can go to and pray. Yeah, and I got my sister who talked to me about it, and then there's the parish sort of thing and I have teachers I listen to who, and like, shook me and woke me up (laughs). ... I mean, I feel like [spirituality and counseling] work hand-in-hand. They're not really, like, totally contradictory or something.

Although the participants mentioned above did not identify any situations in which they would seek counseling in the future, three participants were able to identify circumstances in which they would be willing to seek counseling. Their responses ranged from seeking help with depression, health issues, and family relationships.

Participant #10

Probably my health. About my health. Medical counseling. I have a problem with my digestive system. I would definitely ask for counseling on that one because sometimes you go to the doctor and the doctor would keep prescribing you drugs, and yet you just want to talk to somebody... it would be nice to have somebody just guide you.

Participant #9

Depression.

Participant #2

I'm the youngest and sometimes I feel like – even though I'm the youngest, I have to hold my family up. And it's sometimes hard because sometimes I feel guilty.

*Mental Health Needs of Filipinos in the United States*

Participants were asked to identify what they felt were the greatest mental health needs for Filipinos in the United States. Participants had difficulty identifying what they thought were the greatest mental health needs, and came to the realization that one of the greatest mental health needs among Filipinos in the United States was that mental health was not openly discussed. In response to this question, half of the sample (6 = 50%) noted that even acknowledging a mental health need in the Filipino community was a problem because of the expectation of saving face and keeping up appearances. Just admitting a mental health need would be stigmatized in addition to seeking mental health services.

The list of mental health needs that was generated to this question was relatively circumscribed. Only five participants (5 = 41.7%) mentioned specific mental health needs. The most frequently noted were drugs (2 = 16.7%), and problems associated with tension between assimilation and acculturation (2 = 16.7%). Two participants (2 = 16.7%) also noted that there was a mental health need for more education and outreach

about mental health within the Filipino community. The remaining mental health needs were only mentioned once. They were: gambling, loss of a loved one, communication in marriage, and suicide.

Participant #11

... counseling for people who lost a loved one. Usually takes about a month before you can get over that. And maybe some married couples that are having some problems communicating or trying at least to keep them from, ah, getting, or the situation getting worse like that leads to a divorce or things like that.

Participant #8

Actually it's hard to know, because it's not really something that people openly talk about. They wouldn't talk openly about it. I mean, you wouldn't know what kind of situation they're in. You just wouldn't know because they'll never tell anyone that there is a problem. ... So you never know, I think. We, Filipinos – I know I'm really making an ugly generalization, but we would like – we really, really like to, how would you say uh, save faces in most cases. Put up appearances... So there are things that people, Filipinos, won't reveal.

Participant #7

I don't think a lot of Filipinos seek counseling because again they still have [that] mentality. ... I don't think that they have the mentality in them, which is like, the attitude is bad, "It's my problems, I'll deal with it, I don't need other people to tell me what to do" kind of thing. And I think that culture [is] with a lot of Filipinos. So, some may not talk about problems, some might not trust, I don't think. [Filipinos] need to know it's okay. It doesn't mean that you're insane if you're talking to a counselor. ... [I think the name] is a misconception for Filipinos. When they talk to counselors they think that you have major problems, you have like a major mental problems.

Participant #4

When you see some kids, you know, Filipinos – a lot of them kill themselves. A lot of them commit suicide. A lot of them go do drugs. Because a lot of it is just to please mom and dad. And that is so sad. ... When I say to please mom and dad, I just – it's a stereotype, right? It's a stereotype for a good child, a good child to go to school, become first drummer every single time, because that's what's bragged about. And go to college, get a great paying job, get married, then have children. And have a house, don't forget you need to have a house, shoot. Your own house, and don't borrow from mom and dad, don't do this. Oh, and drive nice cars, and make sure you're wearing brand-name clothes. You know, so it's like, so, so typical in Filipino families to be like that. And then when a teenager gets pregnant, it's like, oh, it's the worst thing. You become like an outcast, you become a shame. ... And then that's even worse. That makes you



feel like, “Gosh, they’re ashamed of me, their kid.” You know? Then that leads to self-destructions, either drugs – I’ve already had more, you know, family members and friends that have committed suicide or turned to drugs. More than I can count on my fingers. That’s like, you know, I don’t think this is something that happened in my mom’s generation. So much of it is happening in my generation.

Participant #2

I want to say a lot of Filipino people are addicts and gamblers. Well, a lot of the ones I know are.

Participant #12

Trying to live a better life here or trying to adapt better, to make their life a little easier, I think. For them to accept at least half of the customs of this country. If you accept at least have of it, and don’t insist on your totally. Some of them insist that they’re Filipinos and nobody’s doing to change them. Well, you change, you came here. You could have just stayed there.

Participant # 10

Education. I think workshops for educating people about mental health. I think maybe short films as part of the education.

*Meeting the Mental Health Needs of Filipino Americans*

Participants were also asked if they had any thoughts about how best to meet the mental health needs of Filipino Americans. The most frequently noted (11 = 91.7%) was exposure of mental health needs and services. Participants suggested a wide array of opportunities for exposure, including sharing personal experiences with mental health; media exposure and advertising; community organizing; exposure in Academia regarding mental health needs of Filipinos; exposure in professional settings through professional conferences; and exposure in the workplace regarding mental health benefits. Less frequently noted (3 = 25%) was the need for more language appropriate counseling services, especially for newly immigrated Filipinos. Only one participant was unable to identify a way to best meet the mental health needs of Filipino Americans.

Participant #9

Hopefully they can find somebody who can speak the language if they're not comfortable with English. ... Hopefully they have a practitioner, like an internist who can refer them to somebody.

Participant #8

I think Filipinos right now fall into at least two segments: those who were born here, and those who move here. So those who were born here or who grew up here think differently than those who move here recently. So those who move here still have a Filipino mindset. Those who are born here or who grew up here have an American mindset. Those who grew up here and who were born here still follow the American system. Like if the doctor says, "Seek a counselor," they would seek a counselor. Those who just recently moved here may have the reluctance to see them... because they still carry that thought that it might cause some sort of stigma, they try to save face, because they don't want... people to think... there's something wrong with their head, that's why they're seeking a counselor. ... [T]hose just who recently move here will feel more comfortable talking to someone who speaks the language because they're not yet used to speaking in English. They're not really that conversational – yet. Although they can understand, but they cannot really relate themselves. And if we're going to be talking about mental health, you have to express yourself. And especially the vernacular... Let's say if I'm a Filipino who moved here, let's say, in my late-20s, the language where I know how to speak well, wherein I can express my feelings is in Tagalog, not in English. I mean I wouldn't get even to express everything, not my entire thoughts, not my entire emotions, because there are words that I can better express in Tagalog, because that's how I grew up. There are things that I won't be able probably to tell, that I have to tell.

Participant #7

... a lot of the [employment health] benefits that I know of, people don't think that counseling is, they usually think that counseling isn't a benefit. So that the benefit might be there but it's useless if you're not familiar [with] how it works of if they fail to even know they can use it...

Participant #4

Gosh, you know, it's so hard to find out about how you can meet those needs. I don't know how you can do it, because probably, what I've done, is just word of mouth. It's like, if somebody asks me, I tell them; I'm not ashamed. But because the stigma's so bad, of people going to therapy in the Philippines or in the Filipino culture here in America – it's like, "Oh, she can't handle it. That's why she's going, because she's crazy". ... I honestly, it's pretty bad but it's pretty sad that it's like this but, it would have to be like a star. Or a media figure to tell everybody that, "Yeah, I was depressed and I sought help and now I feel so much better." Because that's how the Filipino culture is – we're so hooked on T.V., on being star-struck, on seeing all this stuff in the media. We're so hooked on it!

That's probably why it's one of the very few ways you can get to people. Nobody's going to want to go seek counseling themselves. ... [Sharing] [p]ositive outcomes to see that these people are not ashamed of what they did. If they're proud that they did, they might start telling people, that it will start becoming more of a, you know, something that's good. Or, you know, if it were something regulated in school. Like, if I had to see my counselor at least once a month to let him know how I'm doing. Then, if that were instilled in all my cousins, all my cousins that are younger than me, while they're in high school or junior high, if they got used to doing that in school, then they'd have this attitude that, "Oh, it's okay. No, I just go talk to my counselor, he's a psychiatrist or he's a social worker, he understands these things and I think that it helps me." You know, things like that.

#### Participant #1

And so I guess I, by promotion, I guess that that would require a lot more community networking and maybe even grassroots work where, where there are people that are really trying to outreach the community one-on-one, or going door-to-door – some kind of personal interaction. And, um, I don't know, some of the work that my parents do... surveys for the whole Filipino community in [name withheld], and so, well, they're supposed to be more on, like, healthy foods and healthy living. So I feel like that could be applied for mental health services. And we have like, workshops and clinics, where open clinics where people can come in and ask questions. And I think that would really help, trying to expose it to the community. Just being at – I mean, Filipinos have so many festivals and all those kinds of things and there's all those vendors and I don't recall seeing any mental health service. But that's something I'd like to see. ... I think in Academia [exposure to mental health counseling] would help. ... Like, in psychology courses or in – whether you're addressing, let's say, an Asian American course or a psychology course... if they have a course on, or at least a portion of the course on mental health in the Filipino community, and kind of like, bringing awareness into the classroom or in, like an Asian American class, or an ethnic studies class where they would bring up health issues in API communities. ... And even in conferences, I think that's a really good way to hit people. ... I guess I just see different facets of it being taught, where there's one workshop or one section where it's on – you know, the basics, like Mental Health 101, what is it, and then there's another option where it's like you, know, you have some people that are already exposed to mental health and so what can you do, workshop or whatever on what can you do for stress... or how do you deal with problems, deep breathing, or you know, like, those kinds of things.

### *Impediments to Meeting Mental Health Needs for Filipino Americans*

Participants were asked to identify what they considered to be the greatest impediment to meeting the mental health needs for the Filipino community. Most frequently noted (9 = 75%) was the interrelated characteristics of Filipino mindset, pride, and stigma. Less frequently noted included issues of language (3 = 25%), and the lack of Filipinos in the mental health field (2 = 16.7%).

#### Participant #12

I think they're hard-headed in a way... they don't open their mind. Their horizon is not open – it's closed all the time. So most of the ones I know are closed. They're very closed-minded – they just want to stick to their beliefs and that's it. They don't want to see somebody else's.

#### Participant #11

I'm and old Filipino, and usually you have a pride that you have, sometimes you don't want to seek help because you want to solve it yourself, and I think that's a block off between practitioner and the person. But I don't know about the young generation, maybe they're more inclined to seek help right away. When you're born in the Philippines, your custom is different, your way of thinking is different, so when you come over to the States you have to adjust. And then the young ones here, those born here in the States, are really different. So, it all depends. If you're the older generation, sometimes your pride, or you think you can solve it yourself, you don't need help, comes into play.

#### Participant #3

Pride [is the greatest impediment] because I think some people are just too proud. And shame. Because you shame the family or yourself. ... Like my mom always tells me this: "Anything you do in your lifetime reflects on me and how I raised you. So you think about that." It's a lot of pressure.

#### Participant #8

[Filipinos seeking mental health counseling] would feel more comfortable talking to someone that they can talk to in the vernacular, in Tagalog, or whatever dialect that they used to speak when they were still back home in the Philippines.

#### Participant #5

I just think, like, in general, and I'm sure it's prominent in Filipino communities, just overcoming the stigmatization of mental health [is a major impediment]. That, I think. ... it's sad that our physical health tends to have more priority over our mental health because [mental health] informs a lot of our physical health

and well-being. ... I don't know if there's many mental health professionals in the field that understand our culture. I think that's really important too.

Participant #4

It's the stigma that counseling is for sick people and for people who are crazy, who can't handle things for themselves. Weak. It's all negative stuff... It's the judgment and the fear of being judged that make people not want to go seek help, and that make psychiatry and psychology seem so bad.

Participant #1

I think one is the lack of Filipino counselors. I mean, there's a lot of nurses and doctors, but I don't know of any that specialize. ... I mean, I do [know some Filipinos] that are getting their Ph.D's now, but none that are already practicing or have been in practice for a while, so I feel like mentorship... there's a gap in mentorship.

*Overcoming Impediments*

Given these impediments, participants were asked to identify what they thought were the best ways to overcome the impediments to addressing the mental health needs of Filipino Americans that were previously indicated. All participants (12 = 100%) indicated that providing information to the Filipino community about mental health needs and services was the best way to overcome impediments. Participants mentioned a wide range of advertising about mental health services in a way that educates Filipinos about mental health services as well as the types of mental health problems that exist in the Filipino community.

Participant #11

One thing to do is give more information to people, so they'll be able to say, "Oh, maybe it's okay to consult somebody," and things like that. Giving information initially, like giving people some literature and things like that, describing what's available and what's involved. you can do it through, like, uh, bulletins, like put something in a church bulletin or club bulletins, like I know there's a Senior Citizen's halls where they have a lot of information there that [show] Senior Citizens or other people what's available. So at least if they read that they can say, "Oh, there's something for me, there to help me, if I have a problem." That's one way of going.

#### Participant #9

If they can go to a Filipino doctor and maybe they can have services, like in the waiting room, like flyers. Or even in the Filipino stores, like maybe they can have it on the bulletin boards... or the Filipino newspapers, that's another one... if they could advertise there. But then they might feel strange that they have a mental health disorder and might not look for help.

#### Participant #8

Well, I haven't really seen any ads right now... that make people come out and talk. Because I've seen some ads for people who are committing suicide can call a 1-800 number if they need somebody to talk to, but all of those ads, you know, are in English. There's nothing similar being done in Pilipino. Like I've been looking in papers, probably newspapers, like Filipino News and The Guardian. I haven't seen those. I've seen a lot of ads regarding immigration. But not about mental counseling. ... Yeah, if somebody would probably put up an ad, in Tagalog, maybe they'll get a bite. I mean, like, if they really want to reach out, particularly to Filipinos, go to the Philippines newspaper. Put it in a newspaper – Philippine Fortune, Philippine News, and the other local, I mean the other newspapers that cater to the particular market. Go to TFC [The Filipino Channel]! ... Well probably there should be an in depth study. Find out what the common problems are. It could be family problems, it could be job related. I mean, who knows.

#### Participant #5

If you did more outreach or PSA's [Public Service Announcements] or advertising campaigns, like with The Filipino Channel, just within your own community, finding the leaders, like community leaders and get their "buy-in," and support will be able to make a big contribution to community dialogue. And I think that maybe different occasions or something – you know how there's a lot of Filipino performances and things like that – I just think like, so that we can target corporate sponsors to help spread knowledge of the issue.

#### Participant #4

Filipinos love to party, right? So make sure [when] they have [a] festival... fiesta... dinner dance or something [to]... [p]ut like a quarter of a page [advertisement in the event's program with] something for mental health issues[.]

#### *Other Ideas About Meeting the Mental Health Needs of Filipino Americans*

At the end of the interview, participants were asked if they had anything else to say about meeting the mental health needs of Filipinos in the United States. Seven participants (7 = 58.3%) provided additional information. All seven responses were

related to expanding on participants' views that mental health services are a good thing for the Filipino community that need to be utilized more frequently, and the reasons why it should be promoted.

Participant #10

I'd say promote it. Promote it because I don't think it's – it's still not a very accepted, to me. Promote it by education, by way of just, in the family, let them know that it's important. Remove that stigma of, you know, "It's got to mean crazy." Because we're all a part of this. There's no age limit or there's no group. Because we could all be part of the same category. And you know, we could all be normal and then all of a sudden we become abnormal because of situations.

Participant #4

I wish that they'd go more to therapy, I really do. It's so destructive to Filipinos in America. It's like, there's so much more out there, but because of the way our culture is, not that I would change it, it's just that it's so sad to see that our culture is, like, hush-hush, keep everything quiet.

Participant #9

It'd be nice if there is something out there, come to think about it. Like something that they can, like an organization... [that would] [h]elp them with whatever they need, be it mental health, or jobs, or whatever.

Participant #12

To the young generation like you, to help them out if you see it... you have a purpose and maybe you can help them out.

Participant #8

That they need to come out and admit it... that they do have a problem... because keeping it in doesn't solve anything.

## CHAPTER IV

### DISCUSSION

The purpose of this qualitative study was to explore help-seeking behaviors for mental health services among Filipino Americans. Filipinos are now the second largest Asian American population in the United States and Filipino immigration to the United States continues to grow. Filipino Americans have also been identified as one of the high-risk Asian American groups for mental disorders, yet as a population they remain understudied and underserved. Thus the need to know more about what factors determine help-seeking for mental health services among Filipino Americans is all the more urgent. This study involved face-to-face interviews with a sample of convenience comprised of 12 persons of Filipino ancestry currently living in the United States.

#### *Limitations*

Limitations to this study are that it is a qualitative study, and as such cannot be generalized beyond the sample. For this sample of convenience, all of the participants were required to be at least 18 years of age, of Filipino ancestry and fluent in English. It should also be noted that the final sample for this study was skewed on most demographic factors, i.e. age, country of birth, citizenship status, education, occupation, and income. Specifically, 41.7% of the sample was American-born, compared to 32.3% of Filipinos in United States who were American-born. Similarly, the majority of participants in the sample (85.7%) were Foreign-born naturalized citizens, compared to



41.6% of the general population. Participants in the sample had pursued higher levels of education, e.g. 91.7% who had pursued education beyond a high school diploma, compared to 72.4% of the Filipino population in the United States. All of the participants currently worked, or had retired from work in the professional sector, compared with 38.2% of Filipinos in the U.S. that work in the professional sector. Participants in the sample had a median income in the \$50,000-\$75,000 per year range, compared to a median income of \$31,450 for women and \$35,560 for men (Reeves & Bennett, 2004). Finally it should be noted that this sample was also skewed in terms of the number of participants that had sought mental health services (6=50%) versus less than 3% of Filipinos in the U.S. general population.

### *Major Findings*

The major findings of this study were:

1. All participants (12 = 100%) viewed mental health counseling positively and considered it to be useful for people at all stages of the lifecycle and for a full range of problems, e.g. dealing with life transitions, situational stress, addiction, depression and suicide, etc.
2. All participants (12 = 100%) identified the need for outreach and education that is culturally specific to the Filipino community, about the mental health needs of the Filipino community and the mental health services that are available.
3. The vast majority of participants (11 = 91.7%) were familiar with some form of mental health counseling.
4. The majority of participants (9 = 75%) could identify ways that mental health counseling was useful. The most frequently mentioned need for mental health services was for situational stress associated with critical life transitions, e.g. leaving home for college, marriage, divorce, retirement, having children, etc.

5. The most frequently noted impediment (9 = 75%) to seeking help for mental health needs in the Filipino community is the cultural norm around “saving face” or keeping up with appearances.

For the six participants that had actual experience with mental health counseling:

6. All (6 = 100%) only sought counseling after feeling they had exhausted their usual resources to deal with their problems, and felt that they still needed help. All knew about and initially accessed mental health counseling either through college student services or as an employment benefit at work.
7. All (6 = 100%) sought treatment for problems associated with intimate partner relationships. Specifically, half (3 = 50%) sought help with marital problems and half (3 = 50%) sought treatment for depression secondary to the break-up of an intimate partner relationship.
8. The vast majority (5 = 83.3%) stated that treatment met their expectations. The remaining participant acknowledged withdrawing from treatment prematurely. In addition, three participants (3 = 50%) had sought treatment around subsequent life transitions.

The degree to which participants in this study were knowledgeable about and had used mental health services, and the overwhelmingly positive sentiment about the usefulness of mental health services in this sample is inconsistent with the literature on Filipino help-seeking behavior and thus came as somewhat of a surprise. As indicated, there have been few studies that investigate the mental health needs or patterns of help-seeking behavior for mental health services among Filipino Americans. The limited body of literature that does exist suggests that cultural beliefs and the cultural norm around “saving face”, language, cultural conflicts between Filipino and American values and belief systems, ethnic identity development, and colonial mentality impact help-seeking behavior among Filipinos. Of these, “saving face” and colonial mentality are most

frequently noted, and there is the clear suggestion that needing mental health services is stigmatized in the Filipino community.

The high utilization of mental health counseling services within this sample compared to Filipinos in the U.S. general population may be accounted for by a variety of factors. All of the persons that sought counseling had some college education and they initially accessed mental health services through their college counseling service or later professional work. This suggests that the decision to seek mental health counseling may be related to greater acculturation to American values and belief systems that are a result of their affiliation with formal American institutions, e.g., counseling services offered by American colleges and universities and employee assistance programs offered by professional organizations. Both of these American institutions are known for their targeted outreach and education about the need for mental health services. These affiliations may also explain the high level of knowledge about mental health services within the sample, whether participants had sought mental health services or not; and why all participants were so clear about the need for culturally specific outreach to the Filipino community with targeted information about mental health services.

In addition, compared with the total sample, the participants who had previous experience with mental health counseling tended to be the younger half of the sample (42 years old or younger) and born in the United States. Only two participants who had sought mental health counseling were born in the Philippines. However, these two participants had been living in the United States for at least 18 years. This suggests an inverse relationship between age and positive attitudes towards seeking mental health

services and a positive relationship between number of years living in the United States and such positive attitudes towards mental health services.

It is also significant that all of the participants that had sought counseling did so for reasons that were highly circumscribed, i.e., help with intimate partner relationships. This included help with marital problems and depression secondary to the end of an intimate partner relationship. This needs to be further explored in future studies to see if this finding is sustained and if so, to assess for any culturally specific factors at work.

Finally, the existing body of literature suggests that “saving face” is the primary impediment to seeking mental health services among Filipino Americans, followed by colonial mentality. While participants did note that “saving face” was a substantial impediment, there was no mention at all of colonial mentality. There was also little to suggest in the data that mental health services were stigmatized or that saving face was an issue. All participants were equally positive about mental health counseling, whether they had used services or not. Additionally, all participants recommended further outreach and education about mental health services that was targeted to the Filipino community. This would tend to suggest that the biggest impediment to seeking help for mental health services among Filipinos and their underutilization of the mental health services that do exist is their lack of information. Just as this sample, which had a lot of information about mental health services, also had high utilization.

#### *Recommendations for Further Study*

There is a great need for culturally specific outreach and education that is targeted to Filipino Americans regarding mental health needs and services available. This

outreach and education should be specific to Filipinos and extend beyond formal American institutions to include Filipino-specific festivals, newspapers, and other cultural events.

This study also indicates a need for continued research regarding help-seeking behavior for mental health services among Filipino Americans. The nature of the research would be to determine if the findings of this study are sustained with samples more representative of the total Filipino population in the United States. For example, does the suggestion that greater knowledge about mental health services lead to greater utilization of such services? Or, is the fact that there was no mention in this sample of the extensive discourse in the literature about the impact Colonial Mentality has on psychological distress and the mental health needs among Filipinos an artifact of a skewed sample or are there other explanations? What is the relationship(s) between Colonial Mentality, F/Pilipino identity development, and help-seeking behavior for mental health services in the Filipino community?

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## APPENDIX A

### Human Subjects Review Approval Letter

February 6, 2007

Melissa Camorongan  
535 41<sup>st</sup> Street  
Apt. 11  
Oakland, CA 94609

Dear Easa,

Your amended documents have been reviewed and you have done a careful and thorough job in their revision. All is now in order and we are happy to give final approval to your study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain signed consent documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with the project. It should yield some very useful information.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Mary Hall, Research Advisor

## APPENDIX B

### Informed Consent

January 10, 2007

Dear Research Participant:

My name is Easa Camorongan and I am a graduate student at Smith College School for Social Work located in Northampton, Massachusetts. I am currently conducting a research study that explores help-seeking behaviors for mental health services among Filipino Americans. I am focusing on this population primarily because of the underutilization of mental health services among Filipinos as well as the lack of research that exists regarding Filipinos and mental health. I am conducting this research in partial fulfillment of the Masters of Social Work degree, as well as future presentations and publications on this topic.

The criteria for participation in this study are to be a person of Filipino ancestry who is fluent in and able to read English, over the age of 18 years, currently living in the United States, and willing to meet with this researcher to discuss your views. You have been identified as someone meeting these criteria. If you agree to participate in this project, you will be seen in a face-to-face interview at a mutually agreed upon time and place. This interview will last approximately one hour.

At the time of the meeting, you will have the opportunity to ask any additional questions you might have about the study process. You will be asked to sign two copies of this consent form and be given one for your own records before the formal interview can begin. The interview itself will consist of a brief set of structured demographic questions followed by a series of semi-structured and more open-ended questions designed to encourage your reflection on what factors determine help-seeking behavior for mental health services for Filipino Americans. The interview will be audio taped and I may take a few additional notes during the interview. I will subsequently transcribe the audio recording for analysis.

Every precaution will be taken to protect your confidentiality. All of your identifying information will be removed from the audio recordings and transcripts and a numeric code will be developed to identify materials. Only my thesis advisor, and myself will have access to this material. Data collected during the study will be reported in aggregate form only and any quotations included in reports of the study and future presentations will be sufficiently disguised to prevent identification of specific subjects. Informed Consents will be kept separate from all data collected. All research materials will be secured in a locked file during the research and for a period of three years thereafter, in keeping with U.S. federal regulations. After that time, these materials will continue to be secured until they are no longer needed and will then be destroyed.

There are no material benefits to participating in the study. You may benefit from knowing that you are contributing to the professional knowledge base of mental health practitioners that work with Filipino populations. You might receive some personal benefit from having this opportunity to reflect upon and discuss your personal views and experiences. Each participant will receive a summary of the study.

There are few risks anticipated to participation in this study. However, in any experience of self-reflection there is always the possibility that strong feelings may emerge which a participant may feel requires further attention. As a courtesy, each participant will be given a list of mental health resources available to them in the community.

Participation in this study is voluntary. You have the right not to answer any question(s) during the interview. You also have the right to withdraw from this study without penalty at any time up until April 1, 2007 **when the study will be written up.**

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

---

Participant's Printed Name and Signature Date

---

M. Easa Camorongán, MSW Intern (Researcher) Date

Thank you very much for participating in this study.

Please keep a copy of this Informed Consent form for your records.  
Questions regarding any aspect of participation in this study should be directed to:

M. Easa Camorongán, MSW Intern  
Smith College School for Social Work  
Email: [mcamoron@email.smith.edu](mailto:mcamoron@email.smith.edu)  
Mobile: (510) 406-2347

## APPENDIX C

### Recruitment Letter

January 10, 2007

Dear Friend,

Hello! My name is Easa Camorongan, and I am contacting you for your help. I am a graduate student in the field of social work conducting research for my Masters Thesis. The focus of this study is to explore what factors determine help-seeking behavior for mental health services in this country by persons of Filipino ancestry. This is an important question because Filipinos have been identified as an underserved and understudied population in the mental health service delivery system. As a result, Filipinos are at higher risk to have their mental health needs go unrecognized. This is a great opportunity for people in the Filipino community to get involved in a much-needed study and express their views.

In order to participate in this study, you must be

- \*At least 18 years old
- \*Of Filipino ancestry
- \*Fluent in and able to read English
- \*Currently living in the United States
- \*Willing to meet with me to discuss your views

You have been identified as meeting the above criteria and I am inviting you to participate in my study. I have enclosed a copy of the Informed Consent letter for my study that you would have to sign if you agree to participate. It provides further details about the study and the nature of participation being requested. I will be following up this mailing with a call to further discuss your participation.

Thanking you in advance for your time and consideration. I look forward to speaking with you in the next couple of days.

Sincerely,

M. Easa Camorongan  
Masters of Social Work Candidate, 2007  
Smith College School for Social Work  
[www.smith.edu/ssw](http://www.smith.edu/ssw)

# **Are you Filipino? Then I need YOU!**

**I am a graduate student working on my Master's Thesis in the field of social work. This research study seeks to learn what Filipinos think are the greatest mental health needs in our community and what mental health services should be provided. Filipinos have been underserved and understudied placing them at higher risk to have their mental health needs go unrecognized. This is a great opportunity to participate in much needed research that focuses on Filipinos living in the U.S.**

**You are eligible to participate in this study if you are:**

- \*of Filipino ancestry**
- \*at least 18 years old**
- \*living in the U.S.**
- \*fluent in and able to read English**
- \*willing to meet with me to discuss your views**

**Please contact me for further information:**

**Easa Camorongan**  
**[mcamoron@email.smith.edu](mailto:mcamoron@email.smith.edu)**

## APPENDIX E

### Referral Sources

**Asian Community Mental Health Services – Alameda County**

310 8<sup>th</sup> Street, Suite 201  
Oakland, CA 94607  
(510) 451-6729

**Asian Community Mental Health Services – Contra Costa County**

12240 San Pablo Avenue  
Richmond, CA 94805  
(510) 970-9750

**Asian Pacific Psychological Services – Oakland**

255 International Blvd  
Oakland, CA 94606  
(510) 835-2777

**Asian Pacific Psychological Services – Richmond**

3905 Macdonald Avenue  
Richmond, CA 94805  
(510) 233-7555

**Catholic Charities Counseling**

433 Jefferson Street  
Oakland, CA 94607  
(888) 970-2232 or (510) 768-3102   \*\*Clients don't have to be Catholic\*\*

**Family Services Counseling Center**

2208 San Leandro Blvd  
San Leandro, CA 94577  
(510) 483-6715

**The Psychotherapy Institute**

2232 Carleton St.  
Berkeley, 94704  
(510) 548-2250   \*\*Leave a message on the Intake line\*\*

## APPENDIX F

### Demographics & Interview Questions

#### **Segment I: Demographics**

1. How old are you?
2. Where were you born?
3. (If not born in the U.S.) When did you come to the United States? Do you have U.S. citizenship?
4. Have you lived in places other than the United States? If so, where? For how long?
5. What is the highest level of education you have completed? Where? Did you have any school or career specializations?
6. What is your current work occupation?
7. a. Which of the following four categories best describes your current income range?  
b. Which of the following four categories best describes your family's income range when you were growing up?  

<input type="checkbox"/> under \$25,000	<input type="checkbox"/> \$50,000-\$75,000
<input type="checkbox"/> \$25,000-\$50,000	<input type="checkbox"/> over \$75,000

#### **Segment II: Interview Questions**

1. What is your Filipino ancestry?
2. How do you currently identify yourself racially and ethnically?
3. What do you know about mental health counseling? What are your views about mental health counseling? Is it useful? For who and for what?
4. Do you have any personal experience with mental health counseling?
  - a. If yes, can you tell me in general, what was the type of problem? How long had this been a problem before you sought treatment? What other solutions to this problem did you attempt? What made you decide to seek treatment for this problem? Did treatment meet your expectations?
  - b. If no, can you imagine any conditions under which you would seek mental health counseling? Why or why not?

5. In your opinion, what are the greatest mental health needs for Filipinos in this country? What are your thoughts about how best to meet these needs? What do you consider the greatest impediment to meeting the mental health needs of the Filipino community? What are your thoughts about the best way(s) to overcome these impediments?
6. Is there anything else you want to say about meeting the mental health needs of the Filipino community?