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Voices of the Filipino Community Describing The Importance of Family in Understanding Adolescent Behavioral Health Needs

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Abstract

Filipinos are a large, yet invisible minority at high risk for adolescent behavioral health problems. Limited research describes the family as offering a source of positive support for some Filipino youth and yet for some it is also a source of stress and isolation, leading to struggles with adolescent depression and suicidal behavior. This article describes a qualitative study that investigates the role of family when understanding behavioral health needs among Filipino adolescents. Findings highlight the importance of addressing family cohesion when designing interventions aimed at improving the well-being of Filipino youth.

Key Terms

Filipino American; family cohesion; adolescent behavioral health

INTRODUCTION

Filipino Americans are among the fastest growing populations in the United States (U.S.), with a 44.5% increase in population from 2.4 million in 2000 to 3.4 million in 2010 making them the second largest Asian subgroup in the U.S.[1] According to the 2010 Census, they are also the largest Asian subgroup in California.[2] Despite their size, Filipinos are one of the least understood and researched Asian subgroups in the U.S. with respect to both physical and mental health.[3]

Overall, the studies that are available point to an increased need for mental health services and yet, underutilization of such services. For example, depression is much more common among Filipino-Americans compared to other Asian ethnic subgroups. A meta-analysis of

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58 studies reporting a prevalence of Asian-American adults in non-clinical settings described the prevalence rate for depression in Filipino-Americans (34.4%) to be twice as high as that of Chinese-Americans (15.7%).[4] Among those who meet criteria for depressive disorder, Filipinos have a lower prevalence rate for anti-depressant use compared to Non-Latino Whites.[5] Further, although Filipino adults have significantly lower total psychiatric hospitalizations compared with whites, when admitted, their length of stay was significantly longer and severity of illness significantly higher.[6] The Filipino American Community Epidemiological Study (FACES) found that 75% of respondents did not use any type of behavioral health care. Of those who sought care in the past 12 months, 17% sought assistance from friends or relatives, 7% used medical doctors, 4% saw a clergy member or healer, and 3% saw a mental health specialist.[7]

The limited number of studies focusing on Filipino American youth suggests that they are facing high levels of psychological distress. Recent studies highlight their increased need for mental health and social services[8], in part because of higher rates of problem behaviors such as alcohol consumption, tobacco use[9,10], high school and college drop-out[11], and teen births[3,12] compared to other Asian subgroups. Drug use and harmful drinking increases across immigrant generations,[13] suggesting greater risk for younger generations. In fact, Filipino adolescents have higher levels of depressive symptoms compared to non-Hispanic Whites[14] and among females in particular, the highest rates of adolescent suicidal ideation (38.9%) and attempts (27%) of all ethnic groups studied.[15]

For Filipino adults and adolescents in the U.S. and the Philippines, important predictors for suicidal attempts are family conflict and family problems related to family cohesion.[16–18] Family cohesion is defined as the emotional bonding that family members have toward one another.[19] According to the Circumplex Model of marital and family systems, there are four levels of family cohesion: disengaged (very low), separated (low to moderate), connected (moderate to high), and enmeshed (very high). Optimal family functioning occurs at the separated and connected levels of cohesion, and the extremes (disengaged or enmeshed) are problematic for relationships over the long run.[19] When cohesion levels are very low (disengaged systems), family members “do their own thing” with limited attachment to their family. At the other extreme, enmeshed systems, loyalty is demanded among family members and there is too little independence. Previous research has demonstrated that children from families with low socioeconomic status and low family cohesion are more likely to drop out of children’s mental health services compared with children from more cohesive families and higher socioeconomic status.[20,21]

Both enmeshed and disengaged systems have been described among Filipino families.[22,23] First, *respeto*, a core Filipino value may explain the tendency for enmeshed systems. *Respeto*, meaning “respect” refers to acknowledging the rights and feelings of the individual. According to Heras, “a negative aspect of *respeto* is the intolerance for differences and a demand for obedience, making one feel controlled and imprisoned.”[24] Next, disengaged family systems have been described due to conflicts between work and family demands.[25] This is relevant to Filipinos because international migration of parents from the Philippines to the U.S. or elsewhere raises questions about the costs, as well as the benefits, of a livelihood strategy that results in families being divided across national

borders.[23] There is also a growing body of literature that looks at the mental health of children who stay behind in the Philippines when parents migrate overseas to the U.S. and the impact on family relationships when they reunify in the U.S.[26] For example, a study of Filipino adolescents in Canada reported that although youth miss their parents while they are working overseas and long to spend time with them, they also realize that their parents have sacrificed a great deal for them and don't want to disappoint them.[27] Overall, the ability of parents to spend quality time with their children is dependent on work demands.

Given the significant behavioral health disparities described among Filipino adolescents, there is an urgent need to explore the reasons behind these problems so that interventions can be developed. The relative lack of research and documented evidence of the problems facing this community has led to a paucity of programs serving the Filipino –American community as funders are not always aware of the psychosocial issues affecting Filipino families. The objective of this study is to examine the role of the family when understanding behavioral health needs among Filipino adolescents in Los Angeles County. We used principles of community engagement as defined by the Centers for Disease Control[28] and collaboratively worked with the Filipino community partners to conduct this work. We used this approach in order to foster the development of partnerships and new programs and practices.[29] To our knowledge, this is the first study to examine the role of family when understanding mental health needs with parents, adolescents and other community stakeholders in the Filipino community.

METHODS

The current study is part of a larger qualitative investigation that examined unmet mental health needs and recommendations for prevention of behavioral health disorders among Filipino adolescents. This study took place from August 2009 to December 2010.[30] The present analyses focused on the qualitative findings from community stakeholders to describe the role of family when addressing the behavioral health needs of Filipino adolescents.

Study participants were recruited in two phases. Phase 1 comprised of in-depth, semi-structured interviews with 33 individuals from two stakeholder groups: (a) Filipino adolescents and young adults ages 14–21 years (n=16), and (b) healthcare, social service, community leaders, and caregivers (i.e., parents or grandparents) (n=17). Phase 2 consisted of three focus groups (n=18), one comprised of caregivers and two comprised of Filipino adolescents. Participants were residents within Los Angeles County or community leaders or providers that worked in Los Angeles County who were familiar with the Filipino youth population.

Recruitment was conducted using a purposive sampling strategy designed to obtain representative viewpoints of stakeholder groups in a nonrandomized fashion. Participants were recruited from community-based settings, such as high schools, primary care settings, community-based organizations, and churches and via word-of-mouth. We purposefully recruited adolescents who had used and had not used mental health services (i.e. counselor, mental health provider, or church leader) in the past. The median time for the interviews was

45 minutes and the range was from 30 to 90 minutes. Each focus group lasted approximately 90 minutes. All interviews and focus groups were audio-taped and transcribed verbatim. Interviews and focus groups were facilitated by trained researchers who were Filipino-American (JJ, JS). Prior to conducting interviews and focus groups, each ethnographic fieldworker was trained on how to conduct an interview, including procedures for establishing reciprocity and exchange of information and the use of probes to elicit additional detail on a topic. Although lack of English fluency was not an exclusion criterion, all participants were fluent in English since it is one of the national languages of the Philippines.[31] Interviews were conducted in primary care offices, stakeholder's place of employment (i.e., community-based organizations, mental health or primary care clinics), and participants' homes. Focus groups were held in community-based settings such as schools and community-based organizations. The study was approved by the Institutional Review Board at our institution. For adult participants, informed consent was obtained verbally with an information sheet regarding the study. For minors, an information sheet was provided and verbal assent was obtained. We also obtained a waiver of permission from parents for participants who were minors.

Data Collection

Every participant completed a brief demographic survey prior to each interview and focus group. This qualitative study was conducted in two phases: 1) the interview or elicitation phase where key informants were used to elicit the needs and barriers to care of Filipino youth and 2) the focus group, or validation phase in which groups were used to validate the findings from the prior stage. Semistructured interviews were conducted using a guide developed in a prior study[32] by the senior author that examined unmet mental health needs for older adults. The guide was adapted for adolescents and approved by our institutional review board. Participants were asked a series of open-ended questions regarding perceptions of behavioral health needs among Filipino youth. Examples of questions included the following, *"When someone talks about mental health, what kind of things come to mind for you?"*; *"From your perspective what are the most important needs (i.e. top 3 emotional or mental health) of Filipino youth?"*

Adolescent and parent participants were also recruited to participate in focus groups to elicit feedback regarding the most common themes that arose from the interview phase. Focus group members were asked to specifically address the following questions related to mental health needs: (a) Do you agree with the findings presented?; (b) Which findings do you feel to be most relevant to your experience as a Filipino adolescent or Filipino parent/grandparent?; and (c) Which findings do you feel to be least relevant? Based on the format described by Morgan[33], these groups followed a funnel interview structure, starting with broader research-driven issues and narrowing to participant-driven specific illustrations of these issues. For example, although pre-determined probes were used to guide the discussion, the moderator was trained to elicit all relevant opinions related to adolescent mental health needs and perceptions of mental health among the Filipino community and allowed the group members to present their own model of these issues. Participants in the focus groups and interviews did not overlap.

Data Analysis

Four reviewers used a methodology rooted in grounded theory referred to by Wilms et al.[34] as "*Coding Consensus, Co-occurrence, and Comparison*."[35] Eight transcripts were independently coded by four investigators in order to condense the data into analyzable units. Segments of transcripts ranging from a phrase to several paragraphs were assigned codes based on a priori and emergent themes. Themes were generated independently from the narrative summaries by the first author, two research assistants and senior researcher (LP) on the project. Two investigators independently coded the remaining transcripts. Disagreements in assignment or description of codes were resolved through discussion between investigators until consensus was reached. The final list of codes, constructed through a consensus of team members, consisted of a numbered list of themes, issues, accounts of behaviors, and opinions that related to unmet mental health needs and barriers to mental health care utilization among Filipino youth. Based on these codes, the process of axial coding was used by the investigators to generate a series of categories, arranged in a treelike structure connecting transcript segments grouped into separate categories or *"nodes"*, with the assistance of the computer program Atlas.ti Version 6. These nodes and trees were used to create taxonomy of themes that included both a priori and emergent categories and new, previously unrecognized categories. Through the process of constantly comparing these categories with one another, the different categories were further condensed into broad themes that were organized to illustrate linkages across categories (e.g., effects of family cohesion on behavioral health needs).

RESULTS

Sample Characteristics

A brief summary of demographics (i.e., gender, marital status, and birthplace) can be found in Table 1. The majority of caregivers were female and born in the Philippines and almost half of adolescents and stakeholders had these characteristics. There were no meaningful differences by stakeholder group.

The role of family when addressing behavioral health needs

Behavioral health issues affecting Filipino youth are viewed primarily in the context of family and family cohesion. Examples of the four levels of family cohesion are described below disengaged (very low), separated (low to moderate), connected (moderate to high), and enmeshed (very high). Topics such as self-esteem, stress/anxiety, and depression were often discussed within the context of family. In general, connected (moderate to high) family cohesion was described as a facilitator of communication and disengaged (very low) and separated (low to moderate) family cohesion was related to more distress.

Connected (moderate to high) family cohesion

For some, family was a supportive factor. *"My parents weren't as strict. They actually treated me like a friend, my mom and I would really crack jokes. I was just really close to my parents even though they worked a lot, we still had time for family"* (Adolescent).

Another adolescent with a close relationship with his parents shared his desire to achieve greater educational opportunities than his parents, *"We know our parents have gone through hard times, going here from the Philippines and just re-establishing themselves, so we just want to prove to them that we could repay them with everything they have done for us. So we want to prove to them that we could do it too."*

An adolescent who had a friend who had suicidal thoughts also described strong family cohesion as a facilitator to accessing mental health services: *"Her mom goes with her to therapy and then they have a 'mother-daughter thing.' She told me that it made (their) relationship healthier because they used to be just really angry at each other and then after that, they became closer to each other and then it also helped her realize that by hurting herself, she's not doing herself any good."*

Low family cohesion (disengaged and separated)

For others, family factors were additional life stressors. A provider who cares for Filipino adolescents with behavioral health issues also identified low family cohesion as a contributing factor to behavioral problems. *"Their parents neglected them and were abusive emotionally… and since their parents were never home, they had more freedom to try different things because their parents didn't really supervise them throughout their life."*

Many participants described Filipino parents working long hours or having multiple jobs leading to lack of interaction with one another in daily activities. One adolescent described her mother traveling long distances during the weekdays, *"My mom constantly works… Monday through Friday, I see her on the weekends but on the weekends is usually when I'm out, so I barely get to see her…It's hard not having a parent there at home when you need her. I don't even have anyone to talk to…sometimes I don't get to express how I feel about certain things because my mom's not there."* A provider noted that it is particularly hard for Filipino girls to talk to their parents: "*Besides the father, the mother also has to work. Both of them work and the children are left to themselves for awhile. After one or two years, the father gets a better job and then the mother stays home. And I don't know why it is difficult for the girls to speak, talk to their mother. Probably because when they are new here, they understood that the mother didn't have so much time because she also has to work and after working she comes home and will do all the other things that a housewife has to do, and in the strange environment that they are, they are still coping with the outside world and with the parents also struggling in order to earn money. Probably many of our Filipina girls are mabait ('kind' in Tagalog), they understand, they just keep it to themselves whatever problem they have and sometimes that is not really a virtue, not a good practice just to bottle up your problems inside your heart*."

When asked why it is hard for some Filipino parents to show that they are close with their children, an adolescent shared the following:

"Because they're busy…and they don't want to deal with it…just busy with everything, like work and they're tired, and they don't want to deal with it, and they don't want to hear it." The same adolescent was asked what kind of advice he would give to a Filipino parent and he answered:

> "Try to be more close to your child…it really helps for the child to be encouraged and to talk one-on-one alone or hang out together."

Several participants described parents and children immigrating to the United States separately, which can contribute to isolation within the family. An adolescent described immigrating to the U.S. before her mother, "*I moved here when I was 5 and my mom moved here 2 years later. I was with my aunt. It was hard. I was little, so I still missed my mom and stuff…my mother has five kids but one, my oldest brother still lives in the Philippines. My dad, he's in the Philippines*." Overall, there seems to be disconnection or lack of mutual knowledge among family members who have been separated for periods of time.

Low family cohesion was identified by participants as being associated with adolescent risky behaviors such as gang involvement, substance abuse, and having multiple sexual partners. Several adolescents described Filipino peers involved with gang activity: *"I think most of them who are in a gang, they come from, I wouldn't say broken families, but parents who aren't always there for them and it's their way of expressing their anger. (They are thinking) 'they were never there for me, so I'm just going to go out there and be rebellious.'"* (Adolescent)

> "They were kicked out of their houses. Their parents don't really care about them and school wasn't really the right place for them and stuff and they've been to juvie (juvenile hall) when they were kids." (Adolescent).

A provider shared that parents and teachers are often unaware of the risky behaviors that Filipino adolescents are engaged with: *"A lot of Filipino families forget that their kids are having sex, and they're practicing really unsafe habits because they can't talk to their parents about it. They would be having multiple partners, no condoms, no birth control, possibly getting pregnant. Last year, I dealt with 3 Filipinas who were seeing more than 5 partners, were drinking almost every night, and parents didn't know, grades were straight A's. They were so messed up and no one knew. Teachers didn't know, they were star students… We were able to get them the counseling and give them support they needed, but that's what happens I think with the Filipino adolescents. They look so good on paper, no one thinks to ask them anything to be concerned with."*

Enmeshed (very high) family cohesion

Participants also described families with very high family cohesion (enmeshed systems), in which loyalty is demanded, but there is too little independence. For instance, an adolescent described a typical problem he sees with other Filipino families with an interviewer:

> "A typical problem is, 'Oh I fought with my mom, she didn't let me go'… with my friends to the mall or a dance in school.' I have a friend that has a dad and he never lets her go out."

A provider discussed how she helped facilitate communication between a Filipino mother and adolescent daughter, which led to a healthier relationship. This provider encouraged the mother to communicate with her daughter about sex after she discovered that her daughter was using birth control:

> "I had a Filipino mom come in. She said, 'I found my daughter's birth control.' And so we had a talk about that and I told her about my confidentiality and minor rights in California and she said 'I can't believe as a Filipino woman, (you) would allow this to happen.' I said, 'Well, state law basically says I'm allowed to. And second, what is the real issue?' And she said 'I can't believe my daughter didn't tell me. Why doesn't my daughter communicate with me?' I said 'Do you ask your daughter, or do you demand your daughter?' And she said 'You're right, I don't ask her, but that's not how it's supposed to be.' And I said 'Why is it not supposed to be that way?' And she said 'Because that's how we were raised.' And I said, 'Where were you raised?' And she said 'In the Philippines.' And I said, 'Where is she being raised?' ' Oh in the United States.' So different times, different culture, different pressures. I said maybe you can talk to her about why she chose to have sex as opposed to not having sex at all. So this discussion happened and the daughter came back to me and said, 'what did you say to my mom (because) she's so amazing now.' I just told her to talk to you, to listen. And that's the big problem, they're not listening and that's all the kids really want… I think a lot of it is just learning how to talk, and really addressing problems instead of attacking."

An adolescent who immigrated from the Philippines to the U.S. during childhood described how "talking back" to her mother is viewed negatively: *"It's usually my mom who would be surprised if I talked back to her. She would say, "You're changing"… and ask "Is that what you get from your new friends?"* This illustrates how adolescents may be encouraged by peers to "speak their mind", a trait that is encouraged in U.S. mainstream culture and yet, this may be viewed as a form of disrespect by their parents who grew up in the Philippines.

DISCUSSION

Findings from these semi-structured interviews and focus groups suggest that interventions targeting the familial environment may have a significant influence in improving the behavioral health of Filipino adolescents. This is consistent with Filipino cultural values, given the importance of family-centeredness, respect for elders and cultural traits such as *hiya* (shame), *pakikisama* (smooth interpersonal relationships), and *kapwa* (togetherness) within the Filipino community.[36] Our results revealed that adolescents valued and providers promoted open discussion while parents and grandparents felt open discussion was a form of disrespect or talking back. This is consistent with a study by Chung et al in which "parents and grandparents felt that values were transmitted best through traditional Filipino respect for parents who often eschewed open discussion."[22] The important role of parent-child communication and its effects on intergenerational relationships and family dynamics has been described among other Asian subgroups.[36]

These findings are also alarming because previous studies have associated the presence of any family conflict with suicidal ideation among Filipino adolescents.[16,18] A study by Enrile described how stressful life events led directly to suicide attempts, even in the absence of ideation. This is contrary to the literature that states it is usually an accumulation of stressful life events that lead to ideation which then lead to attempts. More than half of the sample

indicated that their most stressful life events were tied to family conflicts such as increased arguments at home or pressure to succeed in school, sports, or other activities.[17]

Overall, participants discussed mental health needs in the context of their family. Some spoke of discord, misunderstanding, and stress within the family in their experiences with mental health and their disinclination to utilize services. Our findings are consistent with previous research that describes family cohesion as a predictor of help seeking and family conflict as leading to less mental health care utilization. These factors could be contributing to the higher prevalence and greater severity of mental illness and lower service utilization rates among Filipino Americans compared to other Asian American subgroups. For example, as previously described by Wolf, family not only provides a good foundation of Filipino identity for many children of immigrants, but can also be a deep source of stress and alienation.[15] The perceived embarrassment often from a strong familial stigma is a major deterrent to seeking help outside of the family. Service utilization may precipitate potential family cultural conflict or jeopardize cohesive family bonds given the magnitude of stigma associated with disclosure of distress and use of mental health treatment in Asian cultural contexts.[34]

On the other hand, separated and connected levels of family cohesion as defined by Olson[37] can serve as a strong protective factor within the Filipino community, and perhaps, low rates of seeking and obtaining counseling may be attributed to resources found within the family. This finding is consistent with other minority groups such as African-Americans that use racial socialization parenting practices.[38] Examples of racial socialization messages that have been associated with increased child mental health services use among African-American families include spiritual and religious coping, extended family caring, and cultural pride reinforcement.[39] These factors have also been described to positively affect the behavioral health of Filipino youth.[40] Rousseau et al also found that “family cohesion plays a key role in shaping adolescents’ perceptions of racism in the host country and in promoting a positive appraisal of their own community”.[27] In designing interventions to address family cohesion, cultural strengths and assets should be targeted. For example, given that the majority of Filipinos are religious, other studies described evidence-based parenting interventions offered in churches as a community-identified and culturally congruent approach to promoting positive parent-child relationships.[41,42] One study also highlights the importance of addressing the unique needs of Filipino families affected by separation upon immigration and conflicts between work and family demands.[27]

This study has several limitations. First, although we purposefully sampled study participants, our findings may not be representative of all Filipinos in the United States. Also, since all of the interviews were conducted in English, our findings may not be generalizable to Filipino families who do not primarily speak English. Also, since our interview scripts did not include questions exploring colonial mentality[38], cultural mistrust, and racial socialization, we were unable to describe the effects of these frameworks on mental health needs and utilization in our sample. Future studies should explore these concepts as they may play an important role in a Filipino American’s experience with distress and help-seeking behavior.

Implications for Family and Community Health

Despite these limitations, our results hold important implications for the care of Filipino American youth and families. The impact of unmet mental health needs is significant in this growing and understudied U.S. population, and future interventions need to focus on strengthening family cohesion between parents and youth. For example, results from this study were shared in a community forum and were instrumental in obtaining funding to offer and evaluate an evidence-based parenting intervention aimed at improving parent-child relationships.[42] Clinicians caring for Filipino youth should consider incorporating screening for the presence of family conflict in order to assess risk for behavioral health disorders, which if untreated, may lead to less optimal life-altering adolescent choices, increased drug use, and suicidal ideations and attempts within Filipino youth. Finally, future research should focus on using community-partnered approaches to develop and evaluate family-focused interventions aimed at preventing the significant behavioral health disparities affecting this population.

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Table 1

Sample Characteristics

		Stakeholders (n=15)	Caregivers (n=11)	Adolescents (n=25)
Gender	Female	8 (53.3%)	8 (72.7%)	13 (52.0%)
	Male	7 (46.7%)	3 (27.3%)	12 (48.0%)
Marital Status*	Married	7 (53.8%)	7 (77.8%)	5 (20.8%)
	Single	5 (38.4%)	2 (22.2%)	17 (70.8%)
	Divorced	1 (7.7%)		2 (8.3%)
Birthplace	US	7 (53.8%)	1 (9.1%)	13 (54.2%)
	Philippines	6 (46.2%)	10 (90.9%)	10 (41.6%)
	Canada			1 (4.2%)

*For adolescents, marital status of parents were reported