The United States is becoming more ethnically diverse, and Asian and Pacific Islanders (APIs) are one of the most rapidly growing ethnic minority groups. Of interest to social workers is how the traditional values and practices of these cultures affect their perceptions of disease and use of health services. This article presents information on perceptions of dementia, caregiving, and help seeking for the API group as a whole, with additional information on five of the major API subgroups—Chinese, Japanese, Filipino, Vietnamese, and Hawaiian. Implications for practice, policy, and research are discussed.

Asian and Pacific Islander American Population

Asian and Pacific Islander (API) Americans are the third largest ethnic minority group in the United States, numbering about 7.3 million in 1990 (U.S. Bureau of the Census, 1991a, 1991b). Among residents age 65 and older, the API elderly group is the fastest growing, projected to have more than tripled between 1980 and 1995 (Young & Gu, 1995). Far from being a homogeneous group, the API label encompasses more than 30 distinct ethnocultural entities, each with its own language and customs (Wykle & Kaskel, 1991).

Among the largest Asian American groups are Chinese, Filipino, Japanese, Koreans, and Vietnamese. Their immigration patterns were influenced by U.S. labor needs and foreign policy. Chinese, Japanese, Korean, and Filipino immigrants initially came to fill low-paying jobs, especially in California and Hawaii, but their immigration was curtailed by the Oriental Exclusion Act of 1924. Immigration rules were relaxed during

A lzheimer’s disease, which causes progressive memory loss and dependence, is estimated to affect 4 million Americans (Yeo & Gallagher-Thompson, 1996). Social workers, regardless of setting in which they work, will find themselves working with more families affected by this disease. At the same time, the United States is becoming more ethnically diverse, and social workers are seeking to broaden their understanding of culturally diverse views of specific health problems, the family’s role in providing care, and how help is sought. In an attempt to help expand knowledge in this area, this article pulls together findings from the literature and from research in Honolulu on the perceptions of five Asian and Pacific Islander (API) American groups—Chinese, Japanese, Filipino, Vietnamese, and Native Hawaiian—on dementia, caregiving, and help seeking. Implications for practice, policy, and research are discussed.

Key words
Asian Americans
dementia
caregiving
help seeking
Pacific Islander Americans
and following times of war when foreign brides of U.S. servicemen and citizens of countries who helped the U.S. cause were allowed to enter the country. The Immigration Act of 1965 liberalized U.S. immigration policy, allowing 20,000 immigrants per year per country, regardless of race or ethnicity, for purposes of occupational immigration (if their skills are needed in the U.S. labor market), family reunification, and vulnerability to political and religious persecution. Because unmarried children under age 21, spouses, fiancées, and parents of U.S. citizens are exempt from the quota limitation, each country can actually send more than 20,000 immigrants per year (Min, 1995).

Among Pacific Islander Americans, the largest groups are Native Hawaiians and Samoans (Young & Gu, 1995). Both of these groups became Americans by virtue of colonization. The Kingdom of Hawaii was overthrown by the U.S. military in 1893 and was administered by the U.S. Department of the Interior until it became a state in 1959 (Blaisdell & Mokuau, 1991). American Samoa became a U.S. Territory in 1900. It was first administered by the Department of the Navy as a coaling station; later it came under the Department of the Interior. American Samoa elected its first governor in 1977 (McDermott, Tseng, & Maretzki, 1980).

The API American group has been called a “model minority” because, as a whole, data on social status suggest that API Americans are better educated and better off financially than other ethnic minority groups (Gelfand, 1994; Markides, 1987; U.S. Department of Health and Human Services, 1985). Researchers who have taken a closer look at the data, however, have found extreme unevenness within the API designation. For example, the 1980 census indicated that a good proportion of API American households had annual incomes of $50,000 or higher; but at the same time, a greater percentage had incomes at or below poverty level compared to European Americans (Lin-Fu, 1988; Liu & Yu; 1985). U.S. residents of Samoan and Southeast Asian descent have been found to be at particularly high risk of poverty (Morioka-Douglas & Yeo, 1990). In educational attainment, the API American group boasted the highest percentage of women age 25 and older who had completed college in 1980; but at the same time, 7.5 percent of them had fewer than five years of elementary school, compared to 2.5 percent among European Americans (Lin-Fu, 1988). This disparity has been referred to as the “bipolar nature” of API status in which the successes of some API groups mask the severe problems of other API groups (Lin-Fu, 1988; Tanjasiri, Wallace, & Shibata, 1995). Even stereotyping within an API group is difficult, because immigration from a single country has likely occurred in several waves; great differences are seen between recent immigrants and those whose families have lived here for several generations (Fabrega, 1969).

Health and service utilization data on API Americans are also likely to be aggregated and suggest that API Americans are healthy and use fewer services than other ethnic groups, especially European Americans. For example, combined data from the 1976–1978 and the 1989–1991 National Health Interview Surveys (NHISs) suggested that more API respondents perceived their health as excellent or good and that fewer reported limitations in activities compared with all other groups (Liu & Yu, 1985; Tanjasiri et al., 1995). Again, a closer look at the data gives a different picture. Although in the 1976–1978 NHISs there was little difference between APIs and white people in number of physician visits per year, the API respondents reported much greater emergency room use and longer hospitalizations than the other group, suggesting that APIs are less likely to have a regular source of care or that they wait too long to use it (Liu & Yu, 1985).

The majority of studies on API utilization of mental health services have found that APIs are underrepresented in both inpatient and outpatient settings (Matsuoka, 1990; Sue, 1994). Frequently mentioned in the mental health literature is a tendency for Asian American groups to somatize mental distress, in part because of the shame and stigma attached to mental illness (for example, Browne, Fong, & Mokuau, 1994; Sue, 1994; Takamura, 1991). Looking specifically at dementia, investigators believe that the age-specific prevalence of dementia is similar throughout the world (White, 1992). Thus, the age-specific prevalence among API Americans should match that of the U.S. population as a whole: about 3 percent of people ages 65 to 74, 19 percent of people ages 75 to 84, and 47 percent of all adults age 85 and older (Evans et al., 1989). In terms of seeking help for dementing conditions, however, it appears that caregivers in ethnic minority communities use fewer services than white caregivers (U.S. Congress, Office of Technology Assessment, 1990) and that API groups are underrepresented in California’s system of dementia diagnosis and treatment centers (Yeo, Gallagher-Thompson, & Lieberman, 1996).
Specific to API perceptions of Alzheimer’s and use of dementia-related services, a search of the literature found very little outside of a book on ethnicity and dementia edited by Yeo and Gallagher-Thompson (1996), which includes chapters on California-based clinical experiences with Chinese, Filipino, and Japanese families.

This article adds to the California-based work by presenting findings from work in Hawaii that has been exploring these issues through key informant interviews and focus group research. Specific methods and timing for each study have been presented elsewhere (Braun, Takamura, Forman, Sasaki, & Meininger, 1995; Braun, Takamura, & Mougeot, 1996). The article presents a compilation of findings about five API groups—Chinese, Japanese, Filipino, Vietnamese, and Native Hawaiian. Information on the immigration and colonization experience of each group is included to aid in understanding culturally specific health perceptions and help-seeking behaviors.

**Chinese**

**History of Immigration**

Chinese immigration to the U.S. began in the mid-1800s. The first large influx (of almost 300,000) was primarily males from southern China who heard of the discovery of gold and the availability of jobs in California. Another 5,000 came to Hawaii during the same period to work on the sugar plantations. Not long thereafter, a series of laws were promulgated in the United States to discourage further Chinese immigration, including the Chinese Exclusion Act of 1882 and the Oriental Exclusion Act of 1924, keeping the total number of U.S.-resident Chinese at below 100,000 for five decades (Wong, 1995).

Immigration restrictions began to relax in the 1940s, in part to recognize China’s position as a U.S. ally in World War II. The Immigration Act of 1965 allowed 20,000 immigrants per year per country (mostly from Taiwan); it was amended in 1981 to allow an additional 20,000 from mainland China and to increase the quota for Hong Kong to 5,000. From 1980 to 1990, the Chinese population in the United States doubled, to 1,645,472. The majority (43 percent) live in California, and another 17 percent live in New York (Wong, 1995).

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**Chinese Cultural Traditions and Values that Affect Caregiving and Help-Seeking Patterns**

Traditional Chinese beliefs, based on Confucian thought, center around the harmony, unity, and survival of the family. Hierarchy is important, and family members have prescribed roles according to gender, age, and birth order. For example, men have more authority than women, children must obey and care for their parents without question or resentment, and the first-born son has the greatest authority and responsibility among siblings. Although elder care was traditionally provided by the wife of the first-born son, today all children are expected to display filial piety and to repay their parents for sacrifices they have made for them (Braun & Browne, 1998; Char, Tseng, Lum, & Hsu, 1980; Elliot, Di Minno, Lam, & Tu, 1996; Huang, 1991).

In this tradition, the family is viewed as more important than the individual. Thus, personal mistakes reflect badly on the entire family and cause shame or loss of face (min chi in Cantonese). Problems of mental instability, acting-out behaviors, and even AIDS and poverty are considered shameful (Sue, 1994). Traditional forms of coping within this structure include activity, endurance, looking the other way, and not thinking too much (Huang, 1991). Children are taught to avoid disclosing private concerns to outsiders, and the Chinese believe that problems are rarely resolved by talking (Lin, 1985; Ryan, 1985).

Discussion of physical ailments, however, is more acceptable. Thus, it is not uncommon to see mental health problems somatized among Chinese Americans, especially recent immigrants (Chang, 1985; Cheung, 1982). In traditional Chinese medicine, illness is seen as an imbalance between yin (the female element) and yang (the male element). Therapeutic interventions involve bringing these forces into balance, and foods or herbs with strong yin and yang qualities may be prescribed (Char et al., 1980). More recently, investigators and practitioners have found Chinese Americans to use Western and Chinese medical services together (Braun & Browne, 1998; Char et al., 1980; Hessler, Nolan, Ogbu, & New, 1975).

**Chinese Views of Dementia and Associated Help-Seeking Patterns**

Work in China by Ikels (1993) presents a perspective on why dementia may not be considered a problem in families of recent Chinese immigrants. Given the traditional practice of living in extended families and the hierarchical power structure based on age, having an elder develop dementia is not always seen as negative, especially if it results in the elder’s loss of power over the household. In
addition, loss of function in old age is expected, and sometimes dementia symptoms are attributed to sensory losses about which, in many parts of China, little can be done. Findings from work with Chinese Americans in California suggested that recent immigrants may interpret dementia symptoms as mental illness (which is shameful), as retribution for individual or family sins, as an imbalance of yin and yang, as improper alignment of the house (according to feng shui), and as possession by an evil spirit (Elliot et al., 1996). These perspectives suggest that help seeking for dementia symptoms among Chinese immigrants might be delayed.

In Honolulu-based work, recent immigrants who participated in our focus groups recognized dementia symptoms and told about their experiences with older adults who were forgetful, talked about the past, talked a lot, repeatedly asked the same question but knew the words to all the old songs, wandered and got lost, and needed 24-hour supervision so they would not leave the stove on and burn down the house. Informants believed that these behaviors were a natural part of old age, but that symptoms were exacerbated by the elder’s move to a new environment. Respondents noted that “those who move here experience a decline in status, loss of peers, and depression. They are homesick for the food, good cultural events, and that they speak the same language” (Braun, Takamura, et al., 1995, p. 124). Cantonese phrases shared with us by informants included chi zin (mixed-up behavior), lo yan chi o zeng (confusion in old age), fan lao wang tong (old return to youth), and sun fa (confused and of a different spirit). The phrase tse ling sung son was also mentioned; this translates roughly as “godnessless spirit” and reflects a belief that if a person’s behavior is unexplained, then his or her body is possessed by an evil spirit (or godnessless).

Related to help seeking, key informants and focus group participants reminded us about respecting the hierarchy within families and about the importance of eating the correct foods and balancing yin and yang to resolve illness. New immigrants said, “We usually handle problems ourselves, but if the problem is serious, we can ask a professional, preferably one that is bilingual and bicultural” (Braun, Takamura, et al., 1995, p. 123).

**Japanese Cultural Traditions and Values that Affect Caregiving and Help-Seeking Patterns**

As in the traditional Chinese culture, traditional Japanese culture emphasizes the importance of interpersonal relationships and interdependence (amae). The preservation of harmony and suppression of conflict are critical factors in positive social relationships (Fujita, Ito, Abe, & Takeuchi, 1991). Also emphasized are filial piety (oyakoko) and the obligation (giri) family members have for each other, especially to parents. Caring for parents is to be done with gratitude, recognizing the balance in reciprocating for the care parents provided in childhood. Not acting accordingly brings great shame (haji) to the family name (Takamura, 1991). Help seeking, however, may be inhibited by the strictures of giri; that is, the expectation that all help would be provided from within the family may result in resistance to obligating oneself to an “outside” provider of help (Braun & Browne, 1998; Fujita et al., 1991).

There are critical differences among the various generations of Japanese Americans (Tempo & Saito, 1996). Those issei (members of the first generation to come to the United States) who are still alive may not speak English and most likely hold to traditional Japanese ways. Many of the nisei (second generation) grew up during the Depression and were incarcerated during World War II. After the war Japanese Americans in Hawaii and California were able to find work, enter government, and run for office. But many nisei became distrustful of the U.S. government following the disruption that accompanied internment; few out-married and many
still subscribe to traditional Japanese values. In contrast, members of the sansei (third) and yonsei (fourth) generations, are more Americanized; few speak Japanese and out-marriage rates are about 50 percent (Nishi, 1995).

**Japanese Views of Dementia and Associated Help-Seeking Patterns**

Japanese words used to label people with dementia symptoms are *kichigai* (from *ki* = behavior and *chigai* = different), which means crazy or insane and is mostly used to describe someone with psychiatric problems, and *bokeru*, which is a verb meaning to go senile or to become forgetful in old age. Although little has been written on Japanese American perceptions of dementia, the mental health literature provides clues as to how Japanese Americans may cope with dementia symptoms. In traditional culture, Japanese attach much stigma to emotional and mental problems, which are attributed to genetics, punishment for past behavior (karma), or poor guidance from the family unit (Shon & Ja, 1982). Such problems are often denied and the affected family member hidden. Talking to an outsider would make the person stand out even more and would cause *haji* (shame and loss of face) for the family.

Mental health practitioners have noticed a general tendency to somaticize illness and to deny the possibility of an emotional component, even when it is quite obvious to the practitioner (Rogers & Izutsu, 1980).

Another Japanese concept that comes to bear is *shikata ga nai*, meaning that the situation cannot be helped and nothing more can be done (Fujita et al., 1991; Tempo & Saito, 1996). Given these traditions, it would be unexpected for Japanese Americans of the issei and nisei generations to seek help for family members exhibiting dementia symptoms until they were quite unmanageable. California-based work confirms the notion that shame and in-group problem-solving strategies keep Japanese Americans from seeking help for family members with dementia symptoms (Tempo & Saito, 1996). Work in both California and Hawaii has found that members of the sansei and yonsei generations are more open to discussing dementia and seeking help for parents and grandparents.

**FILIPINOS**

**History of Immigration**

At the turn of the century, two events occurred that sparked immigration by Filipinos to the United States. With Spain’s loss in the Spanish-American war, the Philippines was ceded to the United States in 1892. At the same time, immigration of cheap labor from China and Japan was being curtailed. Immigration of Filipino laborers was attractive to U.S. agricultural interests, as well as to Filipinos whose country had suffered during years of war. Between 1906 and 1934, almost 120,000 Filipinos came to work on Hawaii sugar plantations, and another 45,000 arrived on the West Coast. Relatively fewer Filipinos immigrated between 1934, when the Philippines was granted commonwealth status, and the passage of the Immigration Act of 1965. Since then, immigration from the Philippines has escalated, and, since the late 1980s, more than 50,000 Filipinos a year have been admitted. In 1990 Filipino Americans numbered over 1.4 million, with 52 percent residing in California and 12 percent in Hawaii (Agbayani-Siewert & Revilla, 1995).

**Filipino Cultural Traditions and Values that Affect Caregiving and Help-Seeking Patterns**

Several traditional Filipino values are relevant to understanding caregiving and help seeking behaviors. *Bahala na* refers to the belief that most things are outside individual control and in the hands of God. *Pakikisama* refers to smooth interpersonal relationships and reflects a high value on harmony and avoiding conflict. It can result in giving into peer pressure and “going with the flow” so as not to cause displeasure. *Hiya* connotes loss of face or shame. *Utang na loob* refers to a debt of gratitude within relationships—for example, children are indebted to parents forever because they raised them, and if someone does another a favor he or she can expect a favor in return (Billones & Wilson, 1990; Braun & Browne, 1998; Ponce & Forman, 1980). Also, the vast majority of Filipinos are Catholic, and these religious values reinforce traditional respect for hierarchy and reliance on God.

In traditional Filipino culture, health problems and accidents are attributed to outside factors such as overwork, exposure, anxiety, punishment from God, curses, souls of the dead, or evil persons. Thus, Filipinos may try home remedies, prayer, and faith healing in conjunction with Western medicine. The literature suggests that Filipinos tend to somaticize emotional and mental distress and that Filipinos underutilize mental health services. Once in the health care system, however, Filipinos tend to ascribe great status to health professionals, often resulting in reserved, quiet behaviors during health
examinations. It is also likely, however, to result in high compliance with prescribed treatment (Billones & Wilson, 1990; Braun & Browne, 1998; Ponce & Forman, 1980; Ying & Hu, 1994).

Children are expected to care for their parents until death. In our Hawaii-based work, informants reflected the value of utang na loob in saying “they gave birth to us, raised us, all those good things, now we must care for them . . . everyone is going to have this responsibility with older people” (Braun, Takamura, et al., 1995, p. 123). Although the California-based work suggested that children may be called on for assistance by birth order (McBride & Parreno, 1996), focus groups in Hawaii found no expectation for a particular child to care for parents; rather it appeared acceptable that a parent live for a time with one child and then with another.

Billones and Wilson (1990) found that Filipino elders may return to the Philippines to receive care, rather than enter an institution. This sentiment was echoed by Hawaii-based informants who said, “We do not like to seek help from the government or announce our problems in church. We care for our own within our extended family network to the extent possible. . . . I would rather return to the Philippines and scout out a nephew to care for me than ask for help from the government” (Braun, Takamura, et al., 1995, p. 123).

Filipino Views of Dementia and Associated Help-Seeking Patterns

In Filipino focus groups in Hawaii, participants expressed familiarity with dementia symptoms, recounting experiences with older adults who had lost control of themselves, wandered, given away their money, needed to be watched 24 hours a day, and remembered clearly the past but not the present. Several descriptive words and phrases were provided by informants. In Tagalog, the country’s national language, phrases included nagbabalik sa pagkabata, meaning going back to childhood, and tumatandang paunrong, meaning growing old backwards. Ulianin, referring to occasional forgetfulness, was also used. In severe cases, one might refer to the person’s mind as wala na (gone, there is none) or tapos na (done or finished). In Ilokano, the language spoken in the northwestern provinces, the suggested word was kabaw, which is apparently quite broad and can be used in reference to someone who is forgetful, retarded, or otherwise impaired mentally. Informants believed that these behaviors were a natural consequence of the aging process and that nothing could be done about them, saying that role reversals were expected. Even if a parent has severe dementia symptoms, continued parent care is the norm. The values of bahala na and utang na loob are evident in this statement: “God does not give jobs to you that you cannot do. If your parents need care, you can do it” (Braun, Takamura, et al., 1995, p. 123).

Vietnamese

History of Immigration

Unlike the previously described groups, Vietnamese immigration to the United States did not start until 1975 with the fall of Saigon to the Vietnamese Communists. That year, about 131,000 Vietnamese who were friendly to U.S. forces were dispersed to sponsoring individuals and community groups who helped them get oriented and find jobs (Matsuoka, 1991). Starting in 1978, members of the general Vietnamese population started fleeing the country and, after substantial periods of time in refugee camps, some of these “boat people” entered the United States. The Orderly Departure Program, established in the 1980s, allowed controlled immigration directly from Vietnam for political prisoners, Amerasians, and those whose family members are U.S. citizens (Rumbaut, 1995).

The 1990 Census estimated the Vietnamese population in the United States at 614,547, a 134 percent increase over 1980. About 46 percent of Vietnamese Americans live in California, and 11 percent live in Texas (Min, 1995; Rumbaut, 1995).

Vietnamese Cultural Traditions and Values that Affect Caregiving and Help-Seeking Patterns

Traditional Vietnamese culture is influenced by two religious philosophies, Buddhism and Confucianism, which emphasize a respect for authority, social order, loyalty, and filial piety. There is a strong expectation for individuals to defer to the goals of the group, especially those of the family. In Vietnam, extended families live together in compounds. Because few live to old age, it is seen as a blessing, and older persons are expected to sit back, enjoy their accomplishments, and give advice. If disabled, old people are cared for within the extended family (Matsuoka, 1991).

For adults, fathers support the household and represent the family in the community, whereas mothers are generally responsible for everything inside the house. Women are somewhat subservient to men and join their husband’s households
after marriage. Adolescents gain self-worth through close relationships with family adults, rather than through associations with peers. They are expected to contribute to family goals and care for their parents when needed (Braun & Browne, 1998; Matsuoka, 1990; Rutledge, 1992).

There is a growing body of literature about mental health needs of immigrants from Vietnam, as well as those from Cambodia and Laos. Ying and Hu (1994) found that Southeast Asians were overrepresented in the mental health system in Los Angeles. Common mental health problems for this group include posttraumatic stress disorder, depression, and anxiety (Flaskerud & Hu, 1994; Kinzie et al., 1990; Ying & Hu, 1994). As in other Asian cultures that tend to somatize mental distress, Southeast Asians often present to the mental health system with complaints of pain and sleep disorders (Flakerud & Hu, 1994; Kinzie et al., 1990). Gold (1992) interpreted these symptoms in terms of the great disruptions that these refugees have experienced, including war and loss of family and livelihood in their home countries and, in the United States, poor English skills, underemployment, and poverty. Acculturation to the United States has also resulted in the undermining of traditional values within the family and role reversal and loss of status for older immigrants (Lin, Tazuma, & Masuda, 1979; Tran, 1991).

Vietnamese Views of Dementia and Associated Help-Seeking Patterns

Work in Hawaii suggests that Vietnamese in America have experience with older people who have dementia-related symptoms. For the most part, respondents saw these symptoms as a natural part of aging. Male informants were more likely to explain symptoms in mechanical terms (“The mind is like a motor engine and so of course when we get old we will lose memories and get confused; if you don’t run it every day, it becomes damaged.”), whereas female informants felt symptoms were exacerbated by culture shock (“This problem is really connected to our stressful and new way of life we have to deal with here and our mind’s ability to adjust.”) (Braun et al., 1996, pp. 222–223).

A number of Vietnamese words relating to mental capacity were identified that could help practitioners find out what might be causing symptoms. Lú lân refers to confusion related to retardation. Lăng trĩ and đằng trĩ refer to the slipping away of memory and loss of memory caused by the absence of the mind. Mất trĩ nhỏ means the mind is lost already; to distinguish if it is lost quickly, as in multi-infarct dementia, the phrase mất trí giấc would be more appropriate. In contrast, bình tâm thán connotes mental illness or high anxiety, and diễm translates as crazy. Overall, however, there was a sense that Alzheimer’s disease was not a critical issue for the Vietnamese community. In the course of focus group interviews in Honolulu, a number of more important issues surfaced including social isolation, inability to speak English, underemployment, crowded living conditions, unfamiliarity with and disapproval of American culture coupled with a widening language and culture gap between parents and their children, and involvement of children in gang activities (Braun & Browne, 1998; Braun et al., 1996).

Whether or not an older family member had dementia symptoms, there was no question that the person would be cared for at home. Informants would not seek medical advice for dementia symptoms, because they believed nothing could cure them.

But informants also recognized that they were in a new culture, with no desire or expectation to return to Vietnam, and that they must be open to new ways, including learning about and taking advantage of services available to residents and citizens. An informant said, “In Vietnam, we have no government services for old people but we have services here; the government provides. In Vietnamese culture, we would not let the parents live alone; we would care for them. But if they have the privilege to live in senior housing [here] and we can get it, OK. They will be more comfortable” (Braun et al., 1996, p. 224).

Respondents also discussed the importance of cultural festivals and recommended that educational efforts be presented at festival-related events (Braun & Browne, 1998).

Native Hawaiians

History

The Hawaiian people (or kanaka maoli) are of Polynesian extraction, sharing a common ancestry with indigenous people across the South Pacific, from New Zealand to Easter Island (Blaisdell & Mokuau, 1991). After contact with the West in 1778, the native population was reduced drastically as Hawaiians contracted and died from measles, tuberculosis, venereal diseases, leprosy, influenza, and other infectious diseases (Stannard, 1989). The importation of labor to Hawaii from China, Japan, and the Philippines (and other
countries) was partly in response to the decimation of the Hawaiian population and, starting in the 19th century, non-Hawaiians have outnumbered Hawaiians in Hawaii (Blaisdell & Mokuau, 1991). Despite increased attention to Hawaiian health, mortality rates for Native Hawaiians continue to be significantly higher than for non-Hawaiian residents of the state (Braun, Look, & Tsark, 1995).

In 1990 the number of Hawaiians in the United States approached 300,000; 70 percent reside in Hawaii (where they make up about 18 percent of the state’s population), and about 14 percent reside in California (Asian American Health Forum, 1990).

Native Hawaiian Cultural Traditions and Values that Affect Caregiving and Help-Seeking Patterns

Family relations and help-seeking behaviors are clearly influenced by a number of traditional Hawaiian values. These include mana (energy that permeates and links all things), lokahi (harmony and unity), pono (rightness or proper order), ‘ohana (extended family and social supports), kokua (mutual help and cooperation), and kuleana (role). In traditional Hawaiian families, each member had his or her kuleana; these roles are very explicit and based on age, gender, class, and ability. As in most oral cultures, kupuna (elders) are respected by younger people as teachers and keepers of knowledge (Blaisdell & Mokuau, 1991).

In traditional Hawaiian culture, illness and other misfortune are thought to be caused by an imbalance of mana or loss of pono. A well-known Hawaiian problem-solving method is ho’oponopono (to correct or to restore pono), which involves prayer, a definition of the problem, self-scrutiny on the part of those out of balance, a determination of restitution, and forgiveness (Blaisdell & Mokuau, 1991). Dreams were also considered as important sources of information, used to solve problems and to forecast events and behaviors. Severe mental distress was sometimes interpreted as a type of possession, and the family would seek help from a kahuna, or Hawaiian healer (Braun & Browne, 1998; Young, 1980).

Spiritual health is considered to be more important than physical health, and Hawaiians are usually very accepting of people who have any kind of illness or disability. Help-seeking behaviors also compromise feelings of fatalism about illness and conflict with the values of the Western health care system (for example, specialization, economic gain, and emphasis on the individual) (Braun, Look, et al., 1995). In addition, Native Hawaiians tend to live in communities that are far from major medical centers, and they are less likely to have comprehensive health insurance. Federal legislation in the 1980s established Native Hawaiian Health Care Systems on each of the major Hawaiian islands, as well as scholarships to support the training of Native Hawaiian health care providers. These efforts have resulted in a significant increase in community-based primary care that is culturally responsive; it is hoped that these services will have a big effect on health status (Braun, Look, et al., 1995).

Native Hawaiian Views of Dementia and Associated Help-Seeking Patterns

In interviews with Hawaiians, we found that most participants had seen older adults with dementia symptoms. Several of our participants were service providers themselves and knew about Alzheimer’s disease. They thought that many of their clients, however, would just attribute dementia symptoms to old age. They recited a saying in pidgin, “more makule, more pupule,” which translates roughly as “the older you get, the more mixed up you get.” Regardless of cause, there was an expectation that the elder would be cared for at home by the ‘ohana and that someone would be acknowledged as accepting this honorable kuleana. This person does not necessarily have to be a daughter or daughter-in-law, because the role would go to the person that the family thought could carry it out best. The designated caregiver would have control of the care and would be expected to call together the ‘ohana to discuss major decisions or problems.

Respondents said that medical care for dementia symptoms would more likely be sought if the family considered the physician to be a friend or a friend-of-a-friend. These findings concur with other studies related to help seeking among Hawaiian families (Braun, Mokuau, & Tsark, 1997). Implications for Practice, Policy, and Research

Implications of these findings include the recognition of diversity among and within API American groups, information about which can help increase cultural sensitivity of providers who serve API groups, the need for policy initiatives that provide for more outreach and education to specific API groups about dementia, and the need for more
research about API Americans in general, as well as research specific to dementia and use of dementia-care services.

**Practice**

The diversity within the API population, which encompasses at least 30 distinctive cultural groups, cannot be overstressed. This article has provided the briefest review of only five API groups. It also emphasized traditional perceptions of dementia, caregiving, and help seeking, rather than describing the variation of perceptions within ethnic groups. This is an important consideration, because differences within API groups may be as significant as across-group differences. For example, the values and behaviors of a sixth-generation Chinese American more likely would resemble those of a fourth-generation Japanese American than those of a Chinese person who has just immigrated from rural China.

Some of the other factors, besides timing of immigration, that influence culturally-linked health behaviors include socioeconomic status, language spoken at home, extent to which the community (and family) is ethnically homogenous, educational attainment, and expectations about returning to one’s ancestral home (Braun & Browne, 1998).

Social workers in health settings who work with individuals of different cultures are encouraged to seek out ways to increase their awareness of cultural values and other factors that affect each group’s perception of health and illness and service-use patterns. At the same time, they must use caution to avoid stereotyping of Asian and Pacific Island populations. Koenig and Gates-William (1995), in their work with dying patients, presented guidelines that have implications for working with dementia families:

- Assess the language used to discuss the patient’s disease.
- Determine whether decisions are made by the patient or by the larger family unit.
- Consider the relevance of religious beliefs.
- Assess the patient’s and family’s degree of fatalism versus an active desire for control of events.

In light of a call to recognize cultural differences, it is interesting that several of our API informants in Hawaii stressed a need to “socialize” our different ethnic groups to American ways. A Filipino informant was adamant that providers reach out to the local Filipino community to say that, bahala na aside, there are things that can be done about health problems, that preventive care is important, and that seeing a doctor about a family member’s dementia symptoms is necessary.

Our Vietnamese informants appeared open to learning how to take advantage of the U.S. health and social service systems. A bilingual Chinese provider made a similar statement in relation to living wills—that is, that service providers must make efforts to explain the concept to new Chinese immigrants despite a hesitance among this group to discuss death and dying (Braun & Nichols, 1997). These same informants asked that outreach efforts and educational materials be offered in the language of the target group and be presented within contexts meaningful to the group. Yet there was an acknowledgment that new immigrants need to learn American ways if they are going to be successful. This perspective supports a two-dimensional view of acculturation (that is, new Americans can adhere to traditional cultural values and understand and follow American norms simultaneously) (Nagata, 1994). They do not have to give up one set of values for the other, and both will influence service acceptability and utilization (Braun & Browne, 1998).

**Policy**

In the area of policy, social workers are committed to ensuring that patients and their families receive the services that would benefit them. Ube and Sue (1991) recommended three possible approaches to increasing service attractiveness and fit. The most expensive, and perhaps for some groups the most effective, approach is to develop parallel services specifically for the target group. Sue (1994) described successful programs in San Francisco and Los Angeles where the language, signs, food and drinks, and providers were of the culture being served.

Specific to dementia services, Elliott et al. (1996) described programs within Chinese agencies and hospitals that provide outreach, education, diagnostic services, and treatment, and Tempo and Saito (1996) described a Japanese American community senior center, all in the San Francisco area.

In Hawaii, parallel services have been established for Native Hawaiians through the Native Hawaiian Health Systems, which fund programs and clinics in Hawaiian communities using Hawaiian health care providers (Braun, Look, et al., 1995).

The second approach is for mainstream providers to add bilingual workers to their facilities and
programs. This approach is facilitated by university admission policies and financial aid programs that support individuals from ethnic minority groups in their pursuit of advanced degrees in health and social welfare. In testing the effectiveness of this approach, Sue (1994) found that API clients stayed in treatment longer and had better outcomes when matched with providers of the same ethnicity who spoke the same language. The Honolulu chapter of the Alzheimer’s Association has taken this route through a contract with Ameri-Corps, which allows the association to employ bilingual VISTA workers in outreach to specific ethnic communities (Braun, Takamura, et al., 1995).

The third approach is for mainstream providers to obtain training for their workers in cultural awareness and sensitivity, emphasizing listening skills and nonjudgmental helping strategies (Mokuau & Shimizu, 1991). For educational institutions cross-cultural awareness and sensitivity training need to be part of the curriculum. This type of training should continue within health and social service agencies, keeping practitioners abreast of findings related to value-linked behaviors, to resources that can facilitate work with individuals of different cultures (for example, translation services), and to increasing appreciation of diversity and the capacity to listen. In addition, patient education and outreach materials should be produced in the appropriate language and recognizable context for specific groups.

Research
Clearly, more research on API perceptions of dementia and service use must be conducted and published. If culturally-sensitive outreach materials and services are to be developed, the profession needs to base them on information gathered directly from these groups, not on assumptions or stereotypes about elderly people of color. This article has sketched out what we have learned about select API groups, but much more needs to be learned. At least in Hawaii-based work, use of qualitative methods, especially focus group interviews (we call them “talk-story” interviews) have been well-received by participants and have revealed a great deal of information about the groups’ worldviews, attitudes, and practices. However, large-scale studies of socioeconomic and health status are also needed (Liu & Yu, 1985; Tanjasiri et al., 1995; Yu & Liu, 1992).

Currently, few national studies offer API respondents the opportunity to specify to which API group they belong. Even when these data are collected, API respondents are usually undersampled. Researchers who are concerned with improving our knowledge of the API American groups have recommended that federal agencies fund studies that expand and standardize API racial or ethnic classification, develop more culturally-appropriate survey measures, oversample API populations, and support a thorough collection and analyses of API data in states where 68 percent of all API Americans live—California, Hawaii, New York, Illinois, and Texas (Liu & Yu, 1985; Tanjasiri et al., 1995; Yu & Liu, 1992).

Conclusion
Dementia is a serious concern faced by elderly people, their families, and the social workers who serve them. As the nation’s cultural diversity increases, researchers and practitioners need to learn more about the histories and traditional cultures of residents of color and gain an understanding about how culturally-linked values affect health and help-seeking behaviors related to dementia. Gaining insights into clients from ethnic minority groups can help social workers increase the cultural competence of their own practices and of the facilities within which they work.

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