Bibliography of Literature Sources on Chinese Older Adults

Prepared by: Hamish Khamisa & Sharon Koehn for the Health of Ethnocultural Minority Older Adults Scoping Review Team
Scoping Review Team

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Introduction

You may be looking at this indexed bibliography on the health and health care access of older adults of Chinese origin living in Canada and similar countries because you are an older person of Chinese origin, a health or multicultural settlement service provider responsible for the health or health care access for this population, or a health or settlement services decision-maker looking for evidence to support your decisions around programming or allocation of funding. Or maybe you are an academic looking for background literature or hoping to identify gaps in the research. This bibliography is the result of a systematic year-long search of a diverse literature that, for several reasons described below, is difficult to ‘mine’ without considerable investments of time that few can afford, hence the decision to share this valuable resource. We have further added value to the bibliography by indexing the references and their abstracts according to several criteria, including country of origin, health condition, type of care (primary, secondary, tertiary), intervention, etc. Explanations of terms within the index ensure that the meaning of each term is transparent.

This bibliography is one of the products of an extensive scoping review of the published and grey literature on the health and health care of ethnocultural minority older adults (EMOA) in general. The review focused primarily on EMOA in Canada, but also included sources from countries similar in their composition of immigrants and health care delivery system, particularly the United Kingdom, Australia, and New Zealand. Materials focusing on the predominant African-American and Hispanic populations in the United States (U.S.) were screened out due to their overwhelming volume and limited relevance to ethnocultural minority experiences in Canada. Similarly, a large number of U.S. articles focusing on barriers to health care access resulting from lack of universal health insurance in that country were also excluded. Even so, the majority of articles retrieved for the review were U.S.–based. The review included sources written in either English or French, but the majority were in English. While most references were articles in peer-reviewed journals, we also included books and book chapters, theses and dissertations, and unpublished research reports. Opinion pieces were excluded. The range of journals in which articles were located was extensive, crossing many disciplines.

From this large collection of materials we elected to create two ethno-specific indexed bibliographies to reflect the two largest groups of immigrants to Canada since 1991: the Chinese and South Asians. Research on older adults of Chinese origin accounted for the majority (almost 45%) of the Canadian studies that we identified, which exceeds their share of the visible minority older adult population (see Table 1, below). This is due, in part, to the establishment of researchers of Chinese-Canadian origin interested in this population.
Many gaps nonetheless remain. Chinese-Canadians are extremely heterogeneous, hailing from many different countries. Some arrive directly from China, Hong Kong, Taiwan, or Macau, while others have previously settled, sometimes for many generations, in other countries with large ‘Chinese’ immigrant populations, e.g. Malaysia, Vietnam, Singapore, etc. These immigrants also differ in all of the determinants of health such as socioeconomic status and gender, as well as the length of time they have been in the country of settlement (some are Canadian-born, i.e., second or third generation, whereas other are first generation who have migrated late in life). They also arrive as different types of immigrants: a relatively small number are refugees, whereas the majority arrive as economic class or family class migrants. Also included here are studies of “Asians” that include older adults of Chinese origin but do not necessarily single out their experiences. This ‘lumping together’ of people from different ‘Asian’ backgrounds is often necessary in quantitative studies for which available sample sizes of one group are often too small for meaningful comparison.

Notably, the terms used to refer to this group in the literature tend to reflect the immigration histories and philosophies of the countries in which they settle. Thus in Canada, they are Chinese-Canadians, in the United States they are included under the rubric of ‘Asian and Pacific Islanders’, in the United Kingdom, they are denoted as ‘Chinese’ (but not Asian, a term reserved almost exclusively for South Asians), and in Australia, they are typically lumped under the broad umbrella of people of Non-English Speaking Background (NESB).

These are the challenges that this bibliography is intended to overcome. Please note that the sources have yet not been reviewed for quality. Do not hesitate to contact us if you have comments, questions or additional sources to add to our database.
Subject Index and Definitions

Each numbered reference included in this bibliography is indexed with as many terms as are applicable. Indexing was based on the abstract summaries alone; the complete articles will undoubtedly reference a broader range of subjects. All 82 topics identified in the full scoping review have been retained in this index, but 24 (just under a third) of these topics have not been explored with EMOA of Chinese origin, indicating possible research gaps and opportunities. These include **(1) health conditions**: aphasia, asthma, hip fracture, incontinence, infectious diseases, specifically HIV/AIDS, influenza and tuberculosis, injury, intellectual disabilities, mental health associated with bereavement or PTSD, obesity, oral health, Parkinson’s Disease, sensory loss or impairment, and sleep disorders; **(2) interventions**: dentist, euthanasia, hearing aids/auditory evaluation, Reminiscence Therapy, spiritual interventions, and (organ) transplantation; and **(3) other**: advocacy and resilience.

There are also five topics for which only one reference was identified and another nine for which there are only two. There is thus scant evidence for another 23% of the topics listed with respect to this population. Naturally, there are many more neglected topics that our search did not reveal within the literature on EMOA overall and hence are not listed here. In sum, there is much work to be done!

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Application</th>
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</thead>
<tbody>
<tr>
<td>Acute [89, 90]</td>
<td>A health (or health related) condition that is acute in nature</td>
<td>This code is applied to abstracts/sources that speak to acute health episodes/illnesses (e.g. heart attack)</td>
</tr>
<tr>
<td>Advance Directives [12, 30, 38, 49, 79, 166, 181]</td>
<td>Intervention for a health condition (or health related condition) using advanced directives</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of advanced directives and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Intervention services directly related to or labeled as 'advocacy'</td>
<td>Used for sources/abstracts that explicitly mention dedicated 'advocacy' services</td>
</tr>
<tr>
<td>Alcohol Consumption [7, 8, 144, 156]</td>
<td>A health (or health related) condition related to alcohol consumption</td>
<td>This code is applied to abstracts/sources that discuss alcohol consumption and/or health issues/problems associated with alcohol consumption</td>
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<tr>
<td>Alcohol/substance abuse treatment [8]</td>
<td>The intervention(s) mentioned include treatments for alcohol and/or substance abuse</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for alcohol and/or substance abuse</td>
</tr>
<tr>
<td>Aphasia</td>
<td>The health condition discussed/mentioned is aphasia</td>
<td>This code is applied to abstracts/sources that discuss aphasia and/or the challenges associated with it to the health and well-being of an individual or a group/population</td>
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<tr>
<td>Health Condition</td>
<td>Description</td>
<td>Code Application</td>
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<tr>
<td>Arthritis</td>
<td>The health condition discussed/mentioned is arthritis</td>
<td>This code is applied to abstracts/sources that discuss arthritis and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
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<tr>
<td>Asthma</td>
<td>The health condition discussed/mentioned is asthma</td>
<td>This code is applied to abstracts/sources that discuss asthma and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
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<tr>
<td>Cancer</td>
<td>The health condition discussed/mentioned is cancer (all types)</td>
<td>This code is applied to abstracts/sources that discuss cancer and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
<td>The health condition discussed/mentioned is cardiovascular disease or related to cardiovascular disease/illness (e.g. hypertension, stroke, heart disease)</td>
<td>This code is applied to abstracts/sources that discuss cardiovascular disease and its variants and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Cardiovascular Diseases - Hypertension</td>
<td>The health condition discussed/mentioned is hypertension (blood pressure) and is a sub-category of cardiovascular disease</td>
<td>This code is applied to abstracts/sources that discuss hypertension and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Caregivers</td>
<td>Intervention for a health or health related condition as being provided by caregivers</td>
<td>This category describes both informal and, to a lesser extent, formal caregivers of ethnocultural seniors. Caregivers’ issues/challenges related to care provision, such as caregiver burden, for an older adult were considered as grounds for inclusion as these issues indirectly impact the availability/quality of care received by the older adult. Often there were references to family care providers and the interactions of cultural beliefs about family caregiving duties/filial piety.</td>
</tr>
<tr>
<td>Chronic Disease [9, 10, 29, 71, 114, 132, 156, 161, 178, 198]</td>
<td>The health condition discussed/mentioned is chronic disease&quot; or &quot;chronic illness&quot; (all types)</td>
<td>This code is applied to abstracts/sources that discuss chronic disease/illness and the challenges associated with it (and/or its treatment) to the health and well-being of an individual or a group/population. The use of the specific term &quot;chronic disease&quot; constituted the application of the code whereas other diseases considered chronic disease (i.e. diabetes) were labeled according to their individual condition names.</td>
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<tr>
<td>Communication [12, 30, 167, 177]</td>
<td>The interventions mentioned focus on/include communication as component to the process of treatment/care</td>
<td>This code is applied to sources/abstracts that mention/discuss communication in any form (i.e. written or verbal) between providers of care and recipients and the possible impact of communication on the success/effectiveness of specific and/or non-specific interventions/treatments.</td>
</tr>
<tr>
<td>Cultural Competence [6, 11, 19, 21, 30, 31, 33, 52, 53, 57, 63, 86, 116, 122, 141, 145, 150, 157, 172, 200]</td>
<td>Intervention - Cultural Competence</td>
<td>Refers to abstracts/sources that mention/recommend 'cultural competence' explicitly and/or types of care that are culturally sensitive or culturally 'aware'</td>
</tr>
<tr>
<td>Day Programs [19, 62, 98, 107, 201, 202]</td>
<td>The intervention(s) mentioned include adult day programs</td>
<td>This code is applied to sources/abstracts that mention/discuss the use of, availability and types of services included in adult day programs. The terms 'day centre' or 'day programs' were included in this category.</td>
</tr>
<tr>
<td>Dementia [2, 11, 14, 45, 65, 71, 72, 73, 74, 80, 128, 133, 143, 175, 193]</td>
<td>The health condition discussed/mentioned is Dementia or cognitive impairment</td>
<td>This code is applied to sources/abstracts that mention or focus on Dementia generally and/or other types of dementias (non-Alzheimer’s).</td>
</tr>
<tr>
<td>Dementia – Alzheimers [34, 35, 45, 70, 75, 77, 85, 144, 176, 182, 206]</td>
<td>The health condition discussed/mentioned is Alzheimer’s Disease</td>
<td>This code is applied to sources/abstracts that mention or focus on Alzheimer’s disease specifically and is referred to specifically by the author. Although it is recognized as a type of dementia, it was coded distinctly from dementia for tracking purposes.</td>
</tr>
<tr>
<td>Dentist</td>
<td>The intervention(s) mentioned the use of/treatments by a dentist</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for oral health issues by a dentist</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Example Codes</td>
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<tr>
<td>Diabetes</td>
<td>The health condition discussed/mentioned is diabetes</td>
<td>[17, 18, 43, 56, 119, 143, 156, 190]</td>
</tr>
<tr>
<td>End of Life</td>
<td>The health issue discussed/mentioned is end of life</td>
<td>[12, 22, 23, 30, 37, 38, 44, 49, 50, 52, 53, 155, 166, 181]</td>
</tr>
<tr>
<td>Ethics [141]</td>
<td>The intervention(s) mentioned the issue of ethics in providing treatment/care</td>
<td></td>
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<tr>
<td>Euthanasia</td>
<td>The intervention mentioned was assisted(or passive) suicide/euthanasia</td>
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<tr>
<td>Exercise [9, 68]</td>
<td>The intervention(s) mentioned include using exercise</td>
<td></td>
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<tr>
<td>Frailty [27, 79, 201]</td>
<td>The health condition discussed/mentioned is frailty</td>
<td></td>
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<tr>
<td>Health Behavior</td>
<td>The abstract mentions or discusses health behaviour (e.g. help seeking behaviour or behaviours related to health).</td>
<td>[2, 3, 6, 23, 73, 85, 92, 124, 126, 130, 132, 163, 188, 198, 208, 209]</td>
</tr>
<tr>
<td>Health Status</td>
<td>The health issue discussed/mentioned is or relates to health status</td>
<td>[4, 10, 15, 24, 26, 28, 31, 33, 43, 59, 60, 81, 98, 99, 101, 104, 105, 111, 113, 114, 117, 118, 124, 125, 129, 132, 142, 143, 149, 152, 162, 185, 187, 189, 190, 198, 205]</td>
</tr>
<tr>
<td><strong>Hearing aids/Auditory evaluation</strong></td>
<td>The intervention(s) mentioned include hearing aids or hearing evaluation</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for hearing loss, in particular the evaluation for (i.e. screening to detect it) or the interventions (such as hearing aids) that directly address hearing loss</td>
</tr>
<tr>
<td><strong>Hip Fracture</strong></td>
<td>The health issue discussed/mentioned are hip fractures</td>
<td>This code is applied to abstracts/sources that discuss hip fractures and/or the challenges associated with it (and/or it’s treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Home Care [19, 28, 41, 95, 104, 110, 147, 201, 202]</strong></td>
<td>The intervention(s) mentioned include services provided to individuals in their homes/residences</td>
<td>This code is applied to sources/abstracts that mention/discuss home care services and the issues associated with their delivery and/or effectiveness as an intervention</td>
</tr>
<tr>
<td><strong>Hospice [50, 155]</strong></td>
<td>The intervention(s) mentioned include the use of a hospice</td>
<td>This code is applied to sources/abstracts that mention/discuss hospices as a treatment/intervention option at the end of life and/or the issues associated with their use (e.g. user or family experience) and/or provider perspectives</td>
</tr>
<tr>
<td><strong>Hospital Services [41, 89, 90, 143]</strong></td>
<td>Intervention for a health condition (or health related condition) for which hospital services were discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role hospital services (such as emergency room) and/or the situations in which this intervention would be considered part of the care strategy for an individual and/or his/her caregivers. While this code could be applied in conjunction with several other codes (e.g. surgery), it reflects the way in which use of the hospital for meeting many tertiary service requirements is communicated in the abstract and in particular whether the types of services situated in a hospital (other than Emergency Room visits) were either highlighted or not.</td>
</tr>
<tr>
<td><strong>Incontinence</strong></td>
<td>The health condition discussed/mentioned is incontinence (any type)</td>
<td>This code is applied to abstracts/sources that discuss incontinence and the challenges associated with it (and/or it’s treatment or management) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Example</td>
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<tr>
<td>Infectious Disease</td>
<td>The health condition discussed/mentioned is infectious disease (of any type)</td>
<td>This code is applied to abstracts/sources that discuss infectious diseases and/or the challenges associated with them (and/or their treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>The health condition discussed/mentioned is a specific type of infectious disease namely HIV/AIDS</td>
<td>This code is applied to abstracts/sources that discuss HIV/AIDS and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. It is a sub-category of the infectious diseases category</td>
</tr>
<tr>
<td>Influenza</td>
<td>The health condition discussed/mentioned is influenza</td>
<td>This code is applied to abstracts/sources that discuss influenza and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>The health condition discussed/mentioned is tuberculosis</td>
<td>This code is applied to abstracts/sources that discuss tuberculosis in older adults and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. As it is a communicable disease, it was placed under in the category of infectious diseases.</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>Intervention for a health condition (or health related condition) for which informed consent is considered</td>
<td>This code was applied to sources/abstracts that discussed the role of informed consent in care delivery and/or the situations in which this issue might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Injury</td>
<td>The health condition discussed/mentioned are injuries (of any type)</td>
<td>This code is applied to abstracts/sources that discuss injuries and the challenges associated with them (and/or their treatment or prevention) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Instrumental/Activities of Daily Living</strong> [10, 27, 103, 108, 114]</td>
<td>The health issue discussed/mentioned relates to the ability to conduct instrumental activities of daily living or activities of daily living</td>
<td>This code is applied to abstracts/sources that mention/discuss individuals' ability to perform instrumental activities of daily living or activities of daily living. The challenges associated with the capacity (or impairment) to perform these activities and/or the impact to the health and well-being of an individual or a group/population may also be discussed.</td>
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<tr>
<td><strong>Intellectual Disabilities</strong></td>
<td>The health condition discussed/mentioned is intellectual disability</td>
<td>This code is applied to abstracts/sources that discuss intellectual disabilities in older adults and/or the challenges associated with them to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Interpreter</strong> [121, 177]</td>
<td>Intervention for a health condition (or health related condition) that requires or is recommended to use an interpreter/translator</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of interpreters/translators and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td><strong>Life Expectancy</strong> [161, 205]</td>
<td>The health issue discussed/mentioned is life expectancy</td>
<td>This code is applied to abstracts/sources that discuss life expectancy and/or it's determinants and/or impact to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Loneliness/Isolation</strong> [19, 60, 62, 67, 93, 122, 135]</td>
<td>The health condition discussed/mentioned is social isolation and/or loneliness</td>
<td>This code is applied to abstracts/sources that discuss social isolation/loneliness in older adults and the presence of/or risks for experiencing isolation or loneliness and the possible impacts on the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Long Term Care</strong> [19, 21, 22, 41, 57, 93, 107, 110, 134, 143, 158, 172, 175, 200, 202]</td>
<td>Intervention for a health condition (or health related condition) for which nursing homes/long term care facilities were recommended/required</td>
<td>This code was applied to sources/abstracts that discussed nursing homes in particular as well as long-term care facilities, the types of care administered within them as well as different options available (or not available) to aging individuals as well as their families in terms of the types of care. Issues related to the transition into long term care/nursing homes also constituted membership into this category.</td>
</tr>
<tr>
<td><strong>Mammography [123, 170, 184]</strong></td>
<td>Intervention for a health condition (or health related condition) for which mammography was considered appropriate</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of mammography and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers, in particular as a preventative measure in screening for breast cancer.</td>
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<tr>
<td><strong>Medication [30, 33, 82, 138, 157, 167, 187, 207]</strong></td>
<td>Intervention for a health condition (or health related condition) for which medication may be involved</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of medication and/or the impacts of their use as part of a care strategy for an individual.</td>
</tr>
<tr>
<td><strong>Mental Health [5, 16, 36, 43, 55, 67, 69, 78, 86, 92, 98, 101, 104, 105, 108, 133, 135, 159, 162, 164, 165, 168, 171, 172, 173, 177, 189, 193, 195]</strong></td>
<td>Health Condition related to Mental Health</td>
<td>Abstracts/sources mentioning of conditions generally referred to as 'mental health', 'mental well-being', 'mental health status' with or without reference to a specific subcategory of mental health condition (e.g. depression). Where there was a disorder mentioned, an effort was made to label it with the corresponding specific code, however there would be instances where the abstract would describe a specific condition and also talk about mental health/illness generally, in which case this code would also apply.</td>
</tr>
<tr>
<td><strong>Mental Health - Abuse [19, 183, 93]</strong></td>
<td>A source that discusses abuse of older adults</td>
<td>This code is applied to abstracts/sources that discuss or mention abuse of older adults - including the many forms of abuse (e.g. physical, psychological) and the connection to/impact on health/well-being.</td>
</tr>
<tr>
<td><strong>Mental Health - Bereavement</strong></td>
<td>The health (or health related) issues related to bereavement</td>
<td>Source discusses the impact of bereavement on health/well-being - e.g. bereavement is associated with risk of depression in late life.</td>
</tr>
<tr>
<td><strong>Mental Health - Depression [1, 7, 11, 20, 40, 66, 94, 96, 97, 100, 102, 106, 113, 118, 137, 144, 146, 148, 172, 179, 180, 198, 203]</strong></td>
<td>Health Condition - Mental Health - Depression</td>
<td>This code is applied to abstracts/sources that discuss depression specifically and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well-being of an individual or a group/population.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Notes</td>
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<tr>
<td>Mental Health - PTSD</td>
<td>The health condition discussed/mentioned is Post-traumatic stress disorder</td>
<td>This code is applied to abstracts/sources that discuss PTSD specifically and/or the challenges associated with it (and/or its treatment) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Mental Health - Suicide</td>
<td>The health issue discussed/mentioned is suicide</td>
<td>This code is applied to abstracts/sources that discuss suicide (attempted and completed) and the challenges associated with attempted suicide and/or its impact to the health and well-being of an individual or a group/population and/or caregivers. Also, the topics of the impact of suicide completion on surviving older caregivers and family are covered by this code.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Intervention for a health condition (or health related condition) for which mental health services were used, recommended or discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of a variety of services termed mental health services and/or the situations in which theses intervention would be considered appropriate to the care strategy for an individual and/or his/her caregivers. There were a variety of terms used to describe &quot;mental health services&quot; from the actual term &quot;mental health services&quot; to specific types of services such as counseling or group therapies for mental health related conditions. Where appropriate, subtypes of services that were clearly mentioned were identified and codes applied (see psychotherapy).</td>
</tr>
<tr>
<td>Mental Health Services –</td>
<td>Intervention for a health condition (or health related condition) for which the mental health service psychotherapy were used, recommended or discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of a variety of services termed mental health services and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. Additional terms and issues that relate to mental health services can be found under the more general category of &quot;Mental Health Services.&quot;</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
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</tbody>
</table>
| **Needs Assessment**  
| [47, 139, 147, 159] | Intervention for a health condition (or health related condition) for which a needs assessment was suggested or performed | This code was applied to sources/abstracts that discussed either the results of or recommended the use of a needs assessment in order to address gaps in understanding on key health or health related issues. |
| **Nutrition**  
| [32, 54, 68, 92, 145, 147, 200, 201] | Interventions that address nutritional/dietary considerations | This code is applied to sources that mention or focus on interventions that speak to nutrition and diet and their impact on health and well-being. |
| **Obesity** | The health condition discussed/mentioned is obesity | This code is applied to abstracts/sources that discuss obesity specifically and the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. |
| **Oral Health** | The health condition discussed/mentioned are considered to fall under 'oral health' | This code is applied to abstracts/sources that discuss issues or disorders/illnesses related to oral health and/or the challenges associated with them (and/or their treatment or prevention) to the health and well-being of an individual or a group/population. |
| **Osteoarthritis**  
| [58] | The health condition discussed/mentioned is osteoarthritis | This code is applied to abstracts/sources that discuss or mention osteoarthritis the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. |
| **Osteoporosis**  
| [140] | The health condition discussed/mentioned is osteoporosis | This code is applied to abstracts/sources that discuss or mention osteoporosis and/or the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. |
| **Pain**  
<p>| [151] | The health condition discussed/mentioned is pain | This code is applied to abstracts/sources that discuss or mention pain generally (i.e. not resulting from a specific illness or disorder) the challenges associated with it (and/or its treatment or prevention) to the health and well-being of an individual or a group/population. |</p>
<table>
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<tr>
<th>Category</th>
<th>Description</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Palliative [52, 53]</td>
<td>Intervention for a health condition (or health related condition) for which palliative care was discussed or considered applicable</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of palliative care and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers, in particular for end of life care issues.</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>The health condition discussed/mentioned is Parkinson's disease</td>
<td>This code is applied to abstracts/sources that discuss or mention Parkinson's disease and/or the challenges associated with it (and/or its treatment) to the health and well-being of an individual or a group/population</td>
</tr>
<tr>
<td>Patient-Centred Care [57, 174]</td>
<td>Intervention for a health condition (or health related condition) for which patient-centred care was discussed</td>
<td>This code was applied to sources/abstracts that discussed the notion of patient-centred care and/or the situations in which this intervention might be considered appropriate to the care strategy and outcomes for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Policy [46, 93, 131, 142, 164, 169, 191]</td>
<td>Intervention for a health condition (or health related condition) for which a policy level action was discussed or recommended</td>
<td>This code was applied to sources/abstracts that discussed impact (actual or potential) that policy might be considered appropriate for. Policies that were already in place as well implications for policy that could possibly be developed were both included in this group.</td>
</tr>
<tr>
<td>Prevention [4, 8, 56, 76, 112, 119, 123, 179, 182, 184, 194]</td>
<td>Interventions that refer to Illness/Disease Prevention</td>
<td>This code is applied to abstracts/sources that mention illness/disease prevention activities as a direct intervention or as part of recommendations/implications.</td>
</tr>
<tr>
<td>Primary Care [1, 7, 28, 41, 55, 112, 133, 136, 143, 203]</td>
<td>Intervention at the Primary Care level</td>
<td>This code is applied to sources/abstracts where the intervention refers to primary care, or the components of primary care including family physicians (general practitioners), community clinics (non-acute/non-tertiary)</td>
</tr>
<tr>
<td>Promotion [32, 68, 69, 70, 128, 208]</td>
<td>Interventions that are directly related to or characterized as being health promotion</td>
<td>This code is applied to abstracts/sources that mention health promotion activities as a direct intervention (e.g. education/awareness) or as part of recommendations/implications.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Example</td>
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<tr>
<td>Reminiscence Therapy</td>
<td>Intervention for a health condition (or health related condition) for which Reminiscence Therapy was considered appropriate.</td>
<td>This code was applied to sources/abstracts that discussed the use of role or potential for benefit of Reminiscence Therapy and/or the situations in which this intervention would be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Research [64, 74, 176]</td>
<td>Intervention for a health condition (or health related condition) for which researching ethnocultural minority older adults was discussed or recommended.</td>
<td>This code was applied to sources/abstracts that discussed the research process or called for additional development of research with respect to ethnocultural minority older adults. The situations in which research has been conducted, the barriers/determinants of quality research as well as the operational considerations are discussed in this group.</td>
</tr>
<tr>
<td>Resilience</td>
<td>The health issue discussed/mentioned is resilience.</td>
<td>This code is applied to abstracts/sources that discuss or mention resilience and/or the factors/determinants that encourage or promote it as well as its influence on the health and well-being of an individual or a group/population in confronting and/or managing illness.</td>
</tr>
<tr>
<td>Screening - Scales [4, 66, 100, 137, 179]</td>
<td>Intervention for a health condition (or health related condition) for which screening using a specific scale was discussed.</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of specific diagnostic scales and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. Many of the scales referenced using this code speak to the use of culturally appropriate scales and/or ways in which to measure health conditions reliably using translated versions of existing scales.</td>
</tr>
<tr>
<td>Sensory Loss</td>
<td>The health condition discussed/mentioned is sensory loss</td>
<td>This code is applied to sources/abstracts that mention or focus on sensory loss or decline (as well as impairment) and is referred to specifically as such by the author. Although it is recognized as a component of aging, all types of sensory loss (not including cognitive impairment/decline) were considered, such as declining vision or hearing. Abstracts/sources may speak to challenges associated with various types of sensory loss (and/or its treatment or management) to the health and well-being of an individual or a group/population.</td>
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<tr>
<td>Sleep Disorders</td>
<td>The health conditions discussed/mentioned are sleep related disorders</td>
<td>This code is applied to abstracts/sources that discuss sleep disorders in older adults and/or the challenges associated with them to the health and well-being of an individual or a group/population.</td>
</tr>
<tr>
<td>Social Care [24, 68, 83, 108, 115, 118, 140, 160, 191, 196]</td>
<td>Intervention for a health condition (or health related condition) for which social care was discussed</td>
<td>Abstracts/sources that mention using 'social care' or sources of care from those around an individual such as family, friends or social networks.</td>
</tr>
<tr>
<td>Social Work [15, 62, 131]</td>
<td>Intervention for a health condition (or health related condition) for which social work was discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of social work and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Intervention for a health condition (or health related condition) for which some type of spiritual' therapy was discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of spiritual interventions (i.e. characterized as spiritual by the authors of the abstract) and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. The contextualization of faith based or spiritually based perspectives and their relationship to health, specifically at the intervention level.</td>
</tr>
<tr>
<td>Category</td>
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<tr>
<td>Surgical [58]</td>
<td>Intervention for a health condition (or health related condition) for which surgery or surgical procedures were discussed</td>
<td>This code was applied to sources/abstracts that discussed surgery or surgical interventions and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. Issues arising from the consideration of surgery as an intervention also were coded using this category.</td>
</tr>
<tr>
<td>Traditional Medicine/Complementary Alternative Medicine [6, 28, 157, 82, 92, 120, 151, 187, 207, 209]</td>
<td>The intervention(s) mentioned include treatments considered to be traditional&quot; or &quot;folk&quot; or complimentary or alternative medicine</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions that are considered to be traditional (e.g. &quot;traditional Chinese&quot; medicine) and/or complimentary/alternative medicine. While it is recognized that not all types of traditional medicine/interventions are considered &quot;CAM&quot; per se, the use of 'alternate systems of health' contained in the definition of CAM does overlap significantly with the use of ethnoculturally 'traditional' systems/interventions.</td>
</tr>
<tr>
<td>Transplantation</td>
<td>Intervention for a health condition (or health related condition) for which organ transplantation/donation were discussed</td>
<td>This code was applied to sources/abstracts that discussed organ transplantation/donation and the situations in which this intervention formed part of a care strategy (or options for care) for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Well Being [13, 25, 31, 33, 42, 47, 61, 81, 115, 131, 139, 148, 192, 196, 199]</td>
<td>Health Condition - Well Being</td>
<td>This code was applied to abstracts that mentioned “well-being&quot; specifically or &quot;quality of life&quot; that included the topics of well-being and/or health/wellness and/or health status.</td>
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References


Examined risk factors for depressive symptomatology among older Chinese immigrants in Auckland, New Zealand. A total of 162 Chinese migrants aged 55 and older and recruited by Chinese community organizations and general practitioners completed the Chinese version of the Geriatric Depression Scale (GDS) and measures of stressful life events, morbidity, self-rated health, acculturation, social support, and service utilization. It was found that 26% of the participants met GDS criteria for depressive symptomatology. No recent migrants (resident in New Zealand less than 12 months) showed symptoms of depression. Multiple logistic regression analysis showed that lower emotional support, greater number of visits to a doctor, difficulties in accessing health services, and low New Zealand cultural orientation increased the risk of showing symptoms of depression. The results indicate that significant numbers of older Chinese migrants appear to be depressed or at risk for depression and that while individuals with depressive symptoms consult general practitioners more than individuals without such symptoms, they report greater difficulty in accessing health services. (MM) (AgeLine Database, copyright 2005 AARP, all rights reserved)


Maps out in individually authored chapters major themes of interest to researchers and policy makers concerned with racial and ethnic (R&E) inequalities in health. The authors, all people at the forefront of research in their particular field, provide state-of-the-art assessments of the research in their area and identify major gaps in data, theory, and research design. The papers represent a broad diversity of scholarly perspectives. Individual chapters explore: official classifications of R&E identification and health disparities; R&E disparities in health and mortality among the U.S. older population; R&E differences in dementia and Alzheimer's disease; the life-course contribution to R&E disparities in health, illustrated with data from Canada; selection processes in the study of R&E differentials in adult health and mortality; selectivity and acculturation in regard to immigrant health; genetic factors in R&E disparities in health; R&E factors, socioeconomic status, and health; the role of social and personal resources in R&E disparities in late-life health; neighborhood influences on R&E disparities in health; R&E disparities in health behaviors; cumulative psychosocial risks and resilience; perceived racism and disparities in health; a neurovisceral integration model of health disparities; geography and R&E health disparities; behavioral health interventions; R&E disparities in health in old age in the United Kingdom; and R&E disparities in health in older South Africans. Chapter references are included. (KM) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)


We explored patterns and reasons for health and social service use among Chinese immigrant elders. Interviews were conducted with 27 Chinese immigrant elders, 11 adult care giving children, and 12 health and social service providers. Content analysis of these data indicated that participants across groups agreed that Chinese elders under-utilize services because of problems related to language,
transportation, cost, long waits for appointments, and because of cultural norms/values related to need for care, preference for self-over professional care, fear, and distrust of western biomedicine, and the obligation to refrain from using formal services. These problems are complicated by geographical dispersion and dialect differences in the local Chinese immigrant community.


Evaluated the psychometric properties of a Chinese translation of the 36-item Short Form Health Survey (SF-36) in the Well Elderly Study, a randomized clinical trial designed to evaluate the effectiveness of preventive occupational therapy services specifically tailored for multiethnic, independent-living older adults. Participants were 361 culturally diverse men and women aged 60 or older. After physician evaluation of their health status, participants were randomized into three treatment groups: occupational therapy group, generalized social activity control group, and non-treatment control group. Participants were evaluated at baseline and at the end of a 9-month treatment period with the SF-36, the Life Satisfaction Index-Z, the Center for Epidemiologic Studies Depression Scale, and the MOS Health Perception Scale. Fifty-two Mandarin-speaking participants aged 64-87 (mean age 73.4) were administered the Chinese translation of the SF-36. The SF-36 translation demonstrated satisfactory reliability and validity, with results generally similar to those reported for older Anglo adults. This finding suggests that a Chinese-translated SF-36 can be used to assess multiple dimensions of health in a Mandarin-speaking population of older adults. (AS) (AgeLine Database, copyright 1999 AARP, all rights reserved)


*No abstract available*


Presents the proceedings of a 1991 symposium on cultural competence in the care of elderly Chinese persons in New York City. Differences in Chinese and western culture and their implications for health care provision to Chinese elderly are explored in relation to the areas of nursing, medicine, social services, and nutrition. Elderly Chinese are not familiar with the concept of health care workers other than doctors and often accept orders only from doctors; however, they are more likely to describe problems to nurses. The approach taken by Chinese doctors and patients in understanding symptoms is more metaphysical than the western cause-and-effect scientific system. The goal of the Chinese doctor is not to find the cause or "foreign entity" causing the illness; rather, it is to find the underlying disharmony in the body of which the illness is a part. Cultural considerations in the provision of social services include the client’s native language facility, educational background, age, sex, and family composition. Many Chinese elderly are eligible for entitlements but do not know where to get help or are too proud to ask. As is true for most elderly people, the Chinese consider health and nutrition very important and are aware of nutritional or medical claims. However, many Chinese elderly also like to have traditional foods that are not healthy and may cause cancer. It is concluded that health care workers must develop their own awareness and that of their patients as well; cultural competence means linking the two viewpoints together. (AY) (AgeLine Database, copyright 1991 AARP, all rights reserved)

Identified correlates of active suicidal ideation and passive death ideation in older primary care patients with depression, anxiety, and at-risk alcohol use. Data came from 2,240 primary care patients aged 65 and older from the Primary Care Research in Substance Abuse and Mental Health for the Elderly study, a multisite, randomized comparative trial. Patients were identified in 3 mutually exclusive groups on the basis of responses to the Paykel suicide questions: no ideation, death ideation, and suicidal ideation. Chi-square, analysis of variance, and polytomous logistic regression analyses were used to identify characteristics associated with suicidal ideation. The highest amount of suicidal ideation was associated with co-occurring major depression and anxiety disorder (18%), and the lowest amount occurred among patients with at-risk alcohol use (3%). Asians had the highest (57%) and African Americans the lowest (27%) proportion of suicidal or death ideation. Fewer social supports and more severe symptoms were associated with greater overall ideation. Death ideation was associated with the greatest medical comorbidity and highest service utilization. Contrary to previous reports, the study failed to find that active suicidal ideation was associated with increased contacts with health care providers. It is concluded that targeted assessment and preventive services should be emphasized for geriatric outpatients with co-occurring depression and anxiety, social isolation, younger age, and Asian or Caucasian race. (SW) (AgeLine Database, copyright 2002 AARP, all rights reserved)


This textbook presents a theoretical framework for assessing and treating alcoholism among older adults and examines the interconnections among loss, grief, aging, and alcoholism. Individual chapters focus on the definition and etiology of alcoholism, losses as precursors to alcoholism among older adults, how alcohol abuse influences the aging process, theories of aging, difficulty in identifying alcoholism ("hidden alcoholism"), alcoholism in special populations (such as ethnic groups), models of intervention, values and attitudes for therapists, an eclectic approach to assessment and grief work, the spiritual component of treatment, dealing with relapse, causes of suicide among older adults and prevention strategies, descriptions of specific alcoholism-treatment programs in the United States and Canada, and future trends and recommendations. Most chapters include a summary, study questions, a glossary of terms, and references. (AS) (AgeLine Database, copyright 2002 AARP, all rights reserved)


**INTRODUCTION:** Increasing physical activity is a goal of Healthy People 2010. Although the health benefits of physical activity are documented, older adults are less physically active than any other age group. The purpose of this study was to examine barriers and facilitators to physical activity and exercise among underserved, ethnically diverse older adults. METHODS: Seventy-one older adults were recruited through community agencies to participate in seven ethnic-specific focus groups: American Indian/Alaska Native, African American, Filipino, Chinese, Latino, Korean, and Vietnamese. Groups were conducted in the participants' primary language and ranged in size from 7-13 participants. Mean age was 71.6 years (range from 52 to 85 years; SD +/- 7.39). Professional translators transcribed audiotapes into the language of the group and then translated the transcript into English. Transcripts were systematically reviewed using content analysis. RESULTS: Suggested features of physical activity programs to enhance participation among ethnically diverse minority older adults
included fostering relationships among participants; providing culture-specific exercise; offering programs at residential sites; partnering with and offering classes prior to or after social service programs; educating families about the importance of physical activity for older adults and ways they could help; offering low- or no-cost classes; and involving older adults in program development. Walking was the exercise of choice across all ethnic groups. Health served as both a motivator and a barrier to physical activity. Other factors influencing physical activity were weather, transportation, and personal safety. CONCLUSION: Findings from this study suggest strategies for culture-specific programming of community-based physical activity programs


Examined 16 indicators of the physical, mental, and social health status of older Chinese living in Beijing and Guangzhou (China) and in Los Angeles, California. Data were collected as part of the Cross National Study of Elderly Chinese and Chinese Americans. Interviews were conducted in 1991 with 500 respondents in Beijing, 504 in Guangzhou, and 204 in Los Angeles. All respondents were 60 and older. Ninety-five percent of the Los Angeles respondents were immigrants, and all but two of the Los Angeles interviews were conducted in one or another of the Chinese dialects. Results show that both the frequency distributions of these indicators and their factor structures are different among the three cities. For example, older Chinese in Los Angeles rated their health status higher and had fewer chronic conditions and illnesses than did older Chinese in Beijing and Guangzhou. They also had fewer mobility limitations than those in Beijing and reported independent activities of daily living that did not differ from either mainland city. Yet the Los Angeles respondents reported more interferences with their daily activities because of their health than did elders in Guangzhou and spent more days in bed due to illness than those in either city. Since both the frequency distributions and the severity ratings for nine chronic diseases also differed markedly among the three cities, it is possible that the differences observed merely reflect differences in the distribution of disease. (WD) (AgeLine Database, copyright 1995 AARP, all rights reserved)


The objective of the Health and Ethnicity Project was to identify unmet need and barriers to the use of psychogeriatric and welfare services by ethnic minority older people living in Liverpool's inner-city. The results presented here are the findings of Phase II of the project in which 71 ethnic minority older people aged 65 years and over were interviewed. These respondents had been diagnosed as suffering from dementia or depression earlier in Phase I. They include Black British, Afro Caribbean and Chinese older people. Findings show a low level of service use in spite of considerable unmet need. Only 8% were in institutions and 46% lived alone. For the 17% living alone in sheltered housing, there was evidence of violence towards wardens, wandering, neglect of rooms and occasional fires. Of the 27% living with a family nearly a half of cases also experienced physical disability. Those in institutions were finding language difficulties and problems in obtaining a suitable diet. Using Yeatts et al.'s typology (1992) 'lack of knowledge' barriers and 'lack of intent' barriers concerned the group as a whole most, i.e. they either did not know of services or perceived them as being culturally inappropriate. Implications for service providers are considerable: to ensure improved access it is necessary not only to invest more in general medical services but to work in partnership with ethnic minority groups to overcome barriers of mistrust and ensure cultural sensitivity in the services offered

Making end-of-life decisions is a painful and difficult process; one that can be intensified by cultural differences between physicians and their patients. The objective of this study was to examine attitudes of Chinese seniors towards end-of-life decisions. We conducted a qualitative survey in a Chinese community centre in Toronto, Canada. Face-to-face interviews, in Cantonese, were conducted with 40 Chinese seniors 65 years of age or older. Respondents based their end-of-life decision making on the following factors: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the Family. Respondents rejected advance directives. Respondents’ attitudes toward end-of-life decision making can be understood through the lens of values from Confucianist, Buddhist and Taoist traditions. Health care workers can best achieve quality end-of-life care - and address the cultural differences that may arise - by focusing primarily on understanding the perspectives of patients and their families, and by continually striving for balanced and open communication at all stages of the caregiving process. (C) 2001 Elsevier Science Ltd. All rights reserved


Provides a summary of theoretical models for understanding the relationship between culture and caregiving, focusing on Asian and Pacific Islander (API) cultures in Hawaii. Suggests that caregiving patterns and service utilization among older adults are influenced by a number of factors, including cultural values and traditions, length of time in the United States, educational attainment, economics, discrimination, the needs of older adults, and the ability of the caregiver to provide care. Provides a brief overview of five API groups (Chinese, Japanese, Filipino, Vietnamese, and Hawaiian), discussing each group’s experience and history in the United States, socioeconomic status, general health status, cultural values, and perceptions of relative caregiving. Discusses the findings from key informant and focus group interviews conducted with members of each group. Discusses the similarities and differences found among the caregiving attitudes of the five cultures, noting the implications for practice, policy, and research. (MM) (AgeLine Database, copyright 1998 AARP, all rights reserved)


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.


Discusses sociodemographic characteristics of the Asian and Pacific Island elderly population and presents issues for social work practice and education. The highly diverse Asian and Pacific Island population, which is composed of more than 30 cultures, doubled in size from 1980 to 1990 in the United States and is now the nation’s fastest growing minority group. Ethnic diversity, geographic location, gender ratios, income and poverty, health status, service use, and cultural values and beliefs
are discussed for this population. Issues for social work practice include identification of barriers to service use and the design of culturally sensitive programs and services. Issues for social work education include an ethnogerontological social work curriculum, curriculum content that reflects the heterogeneity of Asian and Pacific Island elders, and the critical need for data on this population. (SW) (AgeLine Database, copyright 1995 AARP, all rights reserved)

The highly diverse Asian and Pacific Island population in the United States doubled in size from 1980 to 1990 and is now the nation's fastest-growing minority group. This article describes the Asian and Pacific Island elderly population and its ethnic diversity, geographic location, gender ratios, income and poverty, health status, service utilization, and cultural values and beliefs. Also presented are the specific challenges for social workers in practice settings in designing and providing culturally relevant services and programs. A number of suggestions for social work education to meet the needs of this growing aging population are offered, including the development of an ethnogerontological and multicultural social work curriculum and the critical need for data on this population.


Provides a review of the research literature on the mental health services utilization of Asian and Pacific Islander (API) American elders. According to the 1990 United States Census, the highly diverse API American population has doubled in size between 1980 and 1990 and is the nation's fastest growing minority group. Previous studies have illustrated the comparative underuse of mental health services by API Americans, while recent studies have highlighted the risk factors for API American elder's underutilization of services. One study is cited showing that Filipino, Chinese, and Japanese elders were severely underrepresented--relevant to the size of their population--at first admissions to state mental hospitals. Several reasons have been suggested for this low service use, including family, culture, and worker-client problems in interpersonal styles and values. Other studies have found that Asians have lower use rates than whites for inpatient mental health services but higher outpatient service rates. The prevalence of mental health problems among API elders, particularly Chinese, Japanese, Hawaiians, and recent immigrants, are highlighted. The specific needs of recent immigrants, especially Koreans and the Indochinese aged (Lao and Vietnamese), are examined. Recommendations for improved mental health service delivery for API elders are provided, including better use of scarce resources for certain populations with increased risks; improved clinical management and involvement of API elders in the planning of services; and more innovative program design to better target at-risk API populations. (TS) (AgeLine Database, copyright 1995 AARP, all rights reserved)


*No abstract available*


*No abstract available*


Examined factors that affect psychological distress (depression) among older Chinese immigrants. Convenience samples were drawn from 2 community organizations and a senior housing facility in the Houston, Texas, Chinese community. One hundred fifty Chinese immigrants aged 55-86 (mean age 72) who had lived in the United States for 0.5-40 years (mean 10.86 years) completed a self-administered questionnaire that consisted of the Migratory Grief and Loss Questionnaire (MGLQ), Acculturation Scale for the Southeast Asian, Chinese Depressive Symptom Scale, and Immigration Factors Inventory. Results of regression analysis indicated that respondents who had a higher degree of migratory grief experience and a lower English proficiency score, who visited their home country, and were younger, were more likely to experience depression. Among these 4 variables, migratory grief alone contributed to 41.5% of the variance while the remaining 3 variables contributed to 12.4% of the variation. Six issues are discussed in relation to social work practice and service utilization by this group: Chinese immigrants seldom recognize mental health problems; do not seek help; do not trust Western medicine practices, including mental health services; face significant language barriers; encounter a lack of cultural competence in service providers; and must fight the stereotype of Chinese Americans as "model minorities." The MGLQ is appended. (AR) (AgeLine Database, copyright 2002 AARP, all rights reserved)


Elderly Chinese residents in nursing homes in the United States experience cultural and language barriers, encounter Western health care practices, and have difficulty adjusting to a new environment. The purpose of this ethnographic study is to identify, describe, and analyze the factors: clinical, environmental, social, and cultural, that influence the care of elderly Chinese residents in nursing homes. Data were collected through participant observation and interviews on Chinese residents, their families, and nursing home staff at a 100-bed nursing home facility. The mission of this facility is to provide compassionate and quality care that recognizes the ethnic diversity of its residents. Kayser-Jones’ Conceptual Model of Person-Environment Interaction was used to illustrate the effects that the interactions of multiple factors in the physical, organizational, personal-suprapersonal, and cultural and psychosocial environment have on elderly Chinese nursing home residents. It was found that the teamwork between the nursing home operator, Asian community, and the nursing home leadership team was important in helping this facility reach its goals in providing quality care. They have implemented and maintained an organizational structure with the goal of meeting the needs of the Chinese elders and the other residents in the facility (organizational environment). This affects the physical and cultural-psychosocial environment, as this team works together to provide a home-like environment sensitive to the needs of the Chinese residents (physical and cultural-psychosocial environment). Chinese elders seeking long-term care are thus drawn to this facility, one which supports an environment sensitive to the social, psychological, and cultural needs of this population (personal supra-personal environment). The outcome for the resident is that there is a good person-environment fit, resulting in high resident morale and self-esteem and thus, a high level of resident satisfaction. This research has shown that positive outcomes occur for Chinese elders in a nursing home providing culturally-specific care. These findings offer valuable information in helping to develop
and implement interventions to improve the care of Chinese elders in nursing homes. (Author Abstract, used by permission) (AgeLine Database, copyright 2008 AARP, all rights reserved)


Given the increase of cultural diversity of the elderly population in the United States, there is a need for increased sensitivity of culturally diverse residents. Research on the care of terminally ill Chinese elderly individuals in nursing homes is limited. As part of a larger study on end-of-life care in nursing homes, data were obtained on 34 Chinese residents. Data were obtained through participant observation, event analysis, and in-depth interviews with residents and their families, nursing staff, and physicians. The process of providing care was observed from the time residents were identified as terminally ill until their death. The most significant factors influencing the care Chinese residents received were communication barriers, dislike of Western food, and differing cultural beliefs and customs. These findings offer valuable information in helping to develop and implement interventions to improve the terminal care of Chinese elderly individuals in nursing homes.


Explores the social world of elderly Chinese-Canadian women and their patterns of coping with the problems of old age. Twenty-six elderly Chinese widows aged 56 to 88 living in rooming houses in Montreal, Canada, responded to a structured questionnaire; 10 of the women also participated in unstructured interviews. Interviews were also conducted with three community workers and with two Chinese physicians. Data were obtained on the women’s immigration patterns and work histories, activities and social participation, service utilization and service needs, and family relationships. Analysis of the data revealed how the women managed to cope with their problems and how they worked to keep their sense of self-worth and personal efficacy intact in the face of difficulties. Challenges the myths that these women suffer more than older whites because of the double jeopardy of age and ethnicity and that they are buffered somehow by the traditional Chinese values of filial piety. (LS) (AgeLine Database, copyright 1985 EBSCO Publishing, Inc., all rights reserved)


This paper challenges common belief that the aging experience is primarily different for seniors in Asia and those in western cultures. The examination reveals that there are many differences in the life situation of seniors living in mainland China and those living in Canada, with Shanghais seniors living in much greater poverty, with much less education and typically not alone when compared to Canadian seniors whether they be of Chinese origin or not. The Shanghais are also in worse health and perceive themselves to be in worse health. However, when examining the predictors of subjective quality of life, life satisfaction, in both cultures it is social support and health that predict life satisfaction. The form that social support takes (the importance of sons is clearly evident in Shanghai, whereas spouses are more important in Canada) and the particular physical health problems that one might suffer from differ across cultures but it is social support and health that appear to be universal in their affects on our subjective quality of life. Similarly when examining caregivers there are many differences evident across the cultures but when examining subjective burden in both cultures it is the deteriorated health of the care receiver that is the major predictor of burden. The data suggest that there are cross-cultural universals, with particularistic forms.
Compared the experience of aging among older adults in Shanghai, China, with that of Chinese and non-Chinese older adults in Canada. Interviews were conducted with 250 adults aged 65 or older (mean age 82) in Shanghai in 1999. The Canadian data were derived from existing studies: a 1995 study of 830 Chinese adults aged 65 or older (mean age 76) in greater Vancouver and greater Victoria, British Columbia; a 1994 study of 1,278 non-Chinese older adults (mean age 74) in greater Victoria; a 1994 province-wide study of 1,614 caregivers of older adults in British Columbia; a 1998 study of 250 caregivers in Victoria; and national data on older adults (mean age 75) and caregivers from Statistics Canada’s decennial census. It was found that older adults in Shanghai lived in very different housing situations, had fewer financial resources, were in worse health, and received fewer health services than older adults in Canada. The form of social support (generally from sons in Shanghai and from spouses in Canada) and particular physical health problems also differed across cultures. However, factors important for quality of life (life satisfaction for older adults and burden for caregivers) were strikingly similar in both countries. (AY) (AgeLine Database, copyright 2003 AARP, all rights reserved)


Although much gerontological literature is focused on subjective well-being, quality of life, and life satisfaction, we know little about this concept in old age among sub-cultural groups. This paper presents empirical data on subjective well-being among Chinese seniors (age 55 and over) living in seven cities in Canada. It asks whether and to what extent traditional Chinese culture, a culture in which seniors have been historically valued as wise and contributing members to be respected, is related to their evaluation of whether or not life has improved in old age. Among a random sample of 2272 Chinese seniors, some but not all aspects of traditional Chinese culture were related to their valuation of old age. In particular, involvement in that traditional culture, return visits to the homeland, immigration due to family reunion, and ancestor worship were significant predictors but differentially depending on whether the overall scale or specific domains within that overall scale was the dependent variable. The fact that differential aspects of traditional culture contribute to a positive experience of aging suggests we must be careful in generalizing to traditional culture. Importantly, ethnocentric beliefs regarding Chinese culture were not related to any domain of quality of life.


Research on ethnicity and quality of life in old age includes a great diversity of ethnic groups located in a variety of countries. When interest focuses on a particular ethnic group (such as overseas Chinese, Punjabis, or Germans), there tends to be relatively little research on each group. Longitudinal research to examine causal relationships, specifically of the impact of ethnicity on quality of life, is even more scant. This paper focuses on subjective well-being indicators of quality of life. First it examines studies on ethnicity in old age that group ethnic groups as a special category, that is, not individual ethnic groups. There is much evidence that sub-cultural groups within developed nations are disadvantaged when compared with Whites in terms of objective societal indicators such as income and health. However, this objective disadvantage does not necessarily translate to the subjective level. Explanations for this discrepancy tend to refer to cultural notions of family embeddedness, social support and caring. Questions are raised concerning the extent to which these differences are driven by economic disadvantage or are culturally preferred. The studies of individual ethnic groups are examined in terms of whether involvement in ethnic sub-culture is advantageous or disadvantageous. Existing research suggests that it could be either, depending on the circumstances. The particular ethnic group of Chinese Canadian seniors are discussed in some detail. The paper ends with a
comment on some of the methodological difficulties of insuring valid data when studying ethnic groups within developed societies.


This paper examines the modern face of filial piety enactment among Chinese families living away from their homeland. It empirically assesses filial piety practices among a random sample of diasporic Chinese Canadians, by studying the role of sons, daughters and spouses in providing assistance with basic activities of daily living, instrumental activities of daily living and perceptions of support; the relative contribution of the traditional Chinese caring unit (son plus daughter-in-law) with assistance provided; whether source of assistance changes when amount of care is taken into account, when the gendered nature of tasks is taken into account and when controlling for other factors in multivariate analyses. N = 2,272 Chinese seniors (age 55+) living in seven cities across Canada. The findings reveal that, among these diasporic Chinese, patterns found in other Chinese societies are evident in their tendency to live with children, even when the spouse is still living, and the involvement of sons and the son/daughter-in-law unit in providing care. However, similar to recent findings for China, daughters and spouses are involved in all 3 areas of support examined and importantly, their involvement increases as more assistance is provided while that from sons decreases, notably in terms of IADL. The participation of daughters-in-law tends to be lower than that of either sons or daughters. The involvement of spouses increases for perceived or emotional support. The findings suggest a blending of Chinese and Canadian patterns of care and are discussed in terms of the changing but still gendered nature of care.


This paper assesses whether the same factors are predictive of health service utilization among this ethnic group as is true of the general population of seniors. The data suggest that the health of Chinese elders is just as bad as other seniors, and their utilization is very similar. They have a strong preference for Western over Chinese medicine and for Western trained doctors over Chinese practitioners, and use services with Chinese staff, probably because of language. Similarly, the predictors of service use are strikingly similar to predictors revealed in utilization studies throughout the industrialized world. Ability to speak English, immigration history, and country of origin are unrelated to the use of these services. However, approximately half of Chinese seniors also engage in traditional Chinese care. Religious beliefs and a preference for traditional Chinese medicine are strongly predictive of the use of traditional care. It would appear that distinctive culture is related to the use of traditional care, but not the use of the western health care system.

Investigated utilization of health care services by Chinese elders in British Columbia, Canada, and compared it with that of the general population of older adults in Canada. A random sample of 830 adults aged 65-102 (mean age 76) with Chinese surnames in the greater Victoria and greater Vancouver areas was interviewed, with the majority of interviews conducted in Cantonese. Service utilization was measured by asking the number of times respondents used a variety of services (physician, medical support and home care services), their reasons for use, and whether Chinese practitioners were on staff at the service. Respondents were also asked about their use of traditional Chinese medical practices such as acupuncture or herbs. Need was measured in terms of health, illness, and disability, and sociodemographic data were collected. Almost half of the respondents spoke no English, and 73.2 percent reported their largest source of income as the old-age security payment and the guaranteed income supplement. The data suggest that Chinese elders have health
that is similar to that of other older adults, and their utilization of services is similar to utilization figures for the general population. The vast majority see physicians, fewer than half use medical support services, and around 15 percent use home care services. Interestingly, they have a strong preference for western over Chinese medicine and for western-trained doctors over Chinese practitioners. However, they do tend to use services with Chinese staff, probably linked to the high proportion who do not speak or understand English. Similarly, the predictors of service use are strikingly similar to the predictors revealed in utilization studies throughout the industrialized world: ill health is the strongest predictor of use of physician services, while ill health and enabling and predisposing factors predict the use of both medical support services and home care services. Approximately half of the Chinese respondents also engage in traditional Chinese medical care. (SW) (AgeLine Database, copyright)


Compared the level and the predictors of life satisfaction among Chinese older adults living in Vancouver, Canada, and in 2 areas of China: Hong Kong and Shanghai. The sample was composed of persons aged 65 or older: 284 in Vancouver, 366 in Shanghai, and 231 in Hong Kong. Data were collected in face-to-face interviews lasting an average of 1 hour and 15 minutes in which the respondents were asked about chronic health conditions, level of functional ability, health symptoms, social support variables, and sources of income. Multiple regression analysis found that those living in Hong Kong showed the least satisfaction both for overall life satisfaction and for the majority of the domains. In every aspect of life satisfaction, those living in Vancouver were more satisfied than those living elsewhere. Older adults in Shanghai fell in the middle. In all of the cities, health, social support, and economic variables were predictive of life satisfaction. Overwhelmingly, these data point to the importance of location for quality of life and suggest that more research that focuses on comparisons in location is needed. (AS) (AgeLine Database, copyright 2001 AARP, all rights reserved)


Examines the cultural clash between mainstream American health care providers and their Chinese patients. Many traditional Chinese beliefs and values are in direct conflict with western beliefs and values, such as a family-centered life versus individualism, respect for elders versus questioning authority, parent-child centered relationships versus husband-wife centered relationships, and an indirect communication style versus a direct communication style. This can cause conflict with providers around issues such as food and nutrition, medical care and medication, attitudes toward death and dying, and end-of-life decision making. Suggestions for providers are offered: do not stereotype; listen to and learn from patients and families of different cultures; accommodate cultural needs, but do not compromise the standard of care; provide bilingual and bicultural educational materials; and use translators who are nonjudgmental and unbiased. (KM) (AgeLine Database, copyright 1997 AARP, all rights reserved)


Asian American elderly form a heterogeneous group with respect to immigration history, ethnic/cultural background, socioeconomic position, and health and mental health status. This paper provides an overview of the internal heterogeneity within the Asian American elderly population and
identifies those who experience multiple stressors affecting their quality of life. Then it discusses barriers to formal service utilization as well as strengths and deficits of informal support systems. To better serve Asian American elders with their multiple needs for health, mental health, and social services, increased funding is recommended for research on this group, diversification of social service programs in coethnic communities, and increased cultural competence in non-Asian social service agencies.


This exploratory study compared sociodemographic characteristics as well as health and nutritional statuses of Asian American participants with those of white and other minority groups. A larger proportion of Asian American elders were married and had income below the poverty line. Given their language barrier, fewer Asian Americans would have participated in the meal programs if meal sites had not been established in Asian American ethnic neighborhoods. Outreach strategies needed to attract eligible nonparticipating minority elders are discussed.


**Objective.** Immigrants are a vital component of the current and future ethnic aging population in Canada. This study was undertaken to explore the health status of elderly Chinese immigrants in a western Canadian city and to identify the major determinants of their physical and psychological well-being. **Method.** Using a 50% random sample of elderly Chinese residing in three residential complexes occupied exclusively by individuals of ethnic Chinese origin located in downtown Calgary, a total of 147 Chinese seniors were interviewed in their homes by trained, bilingual interviewers using a structured questionnaire that covered a wide range of topics including health status, social network, living arrangements, use of health-related services, and socio-demographic information. **Data analysis.** Descriptive and inferential analyses were conducted using the Statistical Package for the Social Sciences. A principal component factor analysis using varimax rotation was performed to explore the underlying factorial structure of the seven items measuring well-being. The internal consistency of all scales used was assessed by Cronbach’s alpha reliability test. Two multiple ordinary least-squares (OLS) regression models were constructed to identify the major determinants of respondents’ physical and psychological well-being. **Results.** The findings revealed that a majority of the participants described their physical health as good or very good. Results of multiple OLS regression analysis demonstrated that education, country of origin, use of medications, physical mobility, and perceived financial needs were significantly associated with physical well-being, whereas sex, marital status, length of residence, education, and physical mobility were significantly related to psychological well-being. **Conclusion.** Healthcare professionals, service providers, and policy-makers need to understand the significant impact of the various socio-demographic and background variables that contribute to the well-being of community-dwelling Chinese elderly immigrants. The provision of culturally sensitive and linguistically appropriate healthcare, social, and medical services is needed for the growing older Chinese population. Future studies should compare the health status of foreign-born Chinese seniors with those who were native-born, as well those co-residing with adult children.

Alzheimer’s disease is as prevalent among Asian ethnic minority groups as among Caucasians. We explored Asian groups’ utilization of available Alzheimer’s disease services in California, using a uniquely large sample of Asian-Americans. The Minimum Uniform Dataset includes data from nine California Alzheimer’s Disease Diagnostic and Treatment Centers. Of the 9,451 cases included in the Minimum Utilizable Dataset, 4.2% were Asian (primarily Chinese), 0.8% Filipino, 0.3% Pacific Islander, and 75.9% Caucasian. In comparison to their numbers within the nine California countries served, Asian ethnic elders were underrepresented in enrollment by approximately 50%, except at one center where all staff were bilingual. The centers referred a significantly greater proportion of Asian than Caucasian patients for financial help (47.8 vs. 7.4%, P < 0.001), case management (47.8 vs. 22.3%, P < 0.001), and to Alzheimer’s disease day care (41.3 vs. 28.4%, P < 0.05). A significantly greater proportion of Asian caregivers received referrals to caregiver resource centers (32.6 vs. 61.3%, P < 0.001) and financial help (29.6 vs. 4.7%, P < 0.001). A smaller proportion of Asian patients received referrals to home health services than Caucasians (4.3 vs. 14.9%, P < 0.05). Filipino patients were also referred more frequently to financial assistance than Caucasians (P < 0.05). Asians and Pacific Islanders under-enroll at centers specializing in AD care. Bilingual staff at centers specializing in dementia care, training for community physicians who treat these patients, and establishment of caregiver support groups within Asian and Pacific Islander communities may enhance the enrollment of these elders. AD care centers in areas supporting Asian and Filipino families may need to concentrate resources on providing financial assistance in case management.


The underlying premise of this 2-day conference is that a better understanding of cultural diversity will translate to improved outcomes and a better quality of life for all persons affected by Alzheimer disease (AD) and related late-life dementias. A further premise of this article is that thinking about cultural diversity and AD requires bringing together two major areas of inquiry, namely, biology and health-related beliefs and behavior. Of the 281 million American surveyed in the 2000 US census, 62% were white, 13% Hispanic, 12% black, and 4% Asian. Within the major ethnic groups, the proportion of individuals over age 65 varies (14.4% of whites, 4.9% of Hispanics, 8.3% of blacks, and 7.8% of Asians). In this overview, observations are highlighted on the differences in dementia prevalence, risk factors, assessment, and intervention among ethnic minorities. Possible explanations (biologic, belief, and behavior) for these differences are considered and the need for further interdisciplinary research discussed.


Examined the impact of the September 11, 2001, terrorist attacks on older adults in New York City’s Chinatown, a community in close proximity to the World Trade Center. Five focus groups were conducted in June 2002 with 51 individuals who ranged in age from their early 60s to middle 70s. Major themes uncovered in the focus group discussions included the trauma of September 11, extended trauma in the weeks and months after the attacks, posttraumatic stress systems and worsening of health conditions, reactions and feelings about the experience, current medical issues, and ways of coping. Service recommendations focus on the use of group modalities as a milieu for healing, with an emphasis on the use of indigenous organizations as host agencies, narration of individual experiences, re-creation of a kinship network, providing sanction and sanctuary for the grieving process, and facilitation of self-help and empowerment of group members. (MM) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Examined whether Chinese-born frail elderly persons in New York City wished to take part in medical decision making regarding life support interventions in a manner similar to other frail elderly populations. A total of 60 Chinese-born Americans aged 60-97 (mean age 79.31) and 60 non-Chinese individuals aged 61-98 (mean age 83.51) were interviewed concerning their attitudes toward life support interventions and completed the Mini-Mental State Examination, Death Attitude Profile, Locus of Desired and Expected Control, and a values inventory. All respondents were patients in long-term home health care programs. Chinese-born participants freely discussed attitudes concerning death, and 92 percent stated that they had no fear of death, compared with 78 percent for the non-Chinese participants. Forty-two percent of the Chinese-born and 62 percent of the non-Chinese said that they would refuse cardiopulmonary resuscitation (CPR), tube feeding, and artificial respiration. Many persons in both groups stated that although they would not want any form of life support treatments, they had not discussed advance directives with their families because they felt they would be upset or feel imposed upon by such a discussion. (MM) (AgeLine Database, copyright 1996 AARP, all rights reserved)


Compared the values of Chinese and European frail older Americans in their medical decision making. Participants included 120 homebound frail older adults in a long term home health care program: 60 Chinese-born Americans aged 60-97 (mean age 79.31) and 60 Euro-Americans aged 61-98 (mean age 83.51). Participants completed the MMSE, Death Attitude Profile (DAP), Locus of Desired and Expected Control, and inventories assessing values, control and independence, and life events. Two-tailed t-tests revealed significant differences between groups on each of the rating scales. Chinese Americans had a higher acceptance of death, but Euro-Americans had a greater belief in a happy afterlife. Chinese Americans had a greater sense of external control or belief in fate, luck, or powerful others; but Euro-Americans expressed a higher sense of personal control over outcomes in their lives. Results do not support the assumptions that have long been associated with the cultural inhibitions that have precluded discussions of medical decision-making, death and dying, and other end-of-life issues with Chinese older adults. Chinese Americans were not more fearful of death than others, and they freely discussed issues concerning the subject. Many indicated strong beliefs and expressed choices regarding future medical care and end-of-life issues. They were not reticent about sharing personal information. Interviews revealed detailed life histories filled with stories of how each of them had found ways to cope with poverty, starvation, and the trials of war. The English and Chinese versions of the interview materials are appended, along with a summary of statistical terms. (AR) (AgeLine Database, copyright 2001 AARP, all rights reserved)


No abstract available

Examined the effectiveness of a cognitive-behavioral therapy for treatment of minor depressive symptoms in older Chinese Americans. The material was videotaped in eight sessions, approximately 25 minutes in length, to be shown to community-dwelling adults aged 40 and older. In addition, a videotape of muscular relaxation techniques was made. A manual written in Chinese about the content of each class was given to each participant. Twenty-three adults (mean age 71.9) completed eight psychoeducational classes, while seven adults served as a control group. The classes included the rationale of the social learning theories of depression, the relationship between depression and one's thoughts, the effect of activities on mood, and the relationship between interpersonal contacts and mood. Specific homework assignments included keeping a daily record of mood, irrational thoughts, and human contacts and doing muscular relaxation exercises at least once a day. Participants were assessed before and after taking the course, with the experimental group showing significant improvement in their scores on the Hamilton Depression Scale and the Hamilton Anxiety Scale. The control group showed no significant improvement on any of the measures. The study suggests the efficacy of psychoeducational classes in reducing symptoms of depression in community-dwelling Chinese Americans. (SW) (AgeLine Database, copyright 2000 AARP, all rights reserved)


*No abstract available*

42. Databook on Asian American elderly in the Minneapolis-St. Paul Area. (1980). Hamline University, Multidisciplinary Project of Gerontology, St. Paul, MN.

The results of a survey of Asian-American elderly in the Minneapolis-St. Paul, Minnesota, area are presented in over 200 tables. The total population of about 570 consisted of Cambodian, Chinese, Japanese, Korean, Laotian, Filipino, and Vietnamese Asian-Americans over the age of 60. Interviews were conducted among 393 subjects, and results from 381 were used. Highest rates of response were obtained from Cambodian and Filipino groups. All data are classified by ethnic group. Interview items include general demographic data, financial status, living conditions, family relationships, health, nutritional habits, problem areas, domestic division of labor, sociocultural considerations, assistance received, assistance given, knowledge and opinion of helping agencies, assistance needed, political data, and interviewers' observations. Specific items include schooling in native country and the United States, employment and income, assets, expenses, food preferences, English language ability, physical mobility, citizenship, contact with government agencies, and comprehension of interview questions. (RW) (AgeLine Database, copyright 1984 AARP, all rights reserved)


*No abstract available*


The population of older adults in the United States is increasing in cultural diversity. Thus, an appreciation of cultural perspectives regarding end-of-life care may benefit practicing physicians. This article addresses end-of-life care issues from the perspective of Hinduism—a faith embraced by a growing demographic of the U.S. population—and also reviews basic Hindu philosophical concepts salient to caring for patients at the end of life.
Discusses the attitudes of Asian-Indian Hindus toward end-of-life care. Issues related to end-of-life care are not specifically addressed in traditional Hindu philosophy, because of the belief that a unitary life force, called Brahman, connects all existence. Hinduism states that humans are ignorant of the fundamental unity of the cosmos and that a Hindu’s goal is to engage in actions that lead to enlightenment and the realization of the existence of one’s immortal soul (Atman). The way by which one may remove the layers of ignorance preventing one from being aware of the Atman is the basis for karmic theory, which essentially dictates that one's actions leave an imprint on one's life and soul. Because death is viewed as a transition rather than a final conclusion, Hindu attitudes on end-of-life care options may differ radically from perspectives shaped by the Western tradition of bioethics. Three case studies are presented illustrating a Hindu perspective on ethical dilemmas that may arise in geriatric care. (AY) (AgeLine Database, copyright 2005 AARP, all rights reserved)


From the limited information available on Alzheimer's disease and related dementias across ethnic minority groups, this paper describes the prevalence of these diseases and how the cultural values and social conditions of a group influence family caregiving and use of formal services and interventions. This discussion emphasizes the importance of taking into account cultural and social factors (e.g., social class and education) in any examination of Alzheimer’s disease and related dementias—including how shared collective cultural values and beliefs provide a framework for experiences with dementing illnesses.


In Canada, two interesting demographic trends have been underway: an aging population and a growth based upon immigration. These patterns combine to form a new group that seems to have evaded notice. Immigrants are older than the national average and almost 31% of the immigrants from Europe are over 65 years of age. Of the total senior population, 28.4% are immigrants (up from 16.9% in 1981) and 19.4% of all seniors are from Europe. One in twenty seniors in Canada are Asian. Overall, 7.2% of the senior’s population is a visible minority (up from 6% in 1996). These patterns have implications for policy development and service delivery. As immigrants age in Canada, they will have very different expectations for services than non-immigrants and immigrants who aged in their home country. This paper presents the current statistical data and presents recent research under the Metropolis project on senior immigrants and integration. It offers recommendations for policy planners and service providers in health and social welfare services. This research contributes to the “forging of our social future.”


The Canadian Ethnocultural Council (CEC), with assistance from its project partners and national network of contacts, conducted a needs assessment study of ethnic seniors and healthy aging. Information for the study was gathered by using a well-defined questionnaire and by interviewing. In total, 352 seniors from 18 ethnic communities responded; 58.4% of the respondents were women and 41.6% men. These seniors were questioned about their physical, mental, emotional, social and spiritual well-being. Data from the survey provide a broad overview of the perceptions, practices, and needs of seniors in ethnic communities.

This volume provides critical and intensive reviews in the areas of biological sciences, behavioral and social sciences, health and clinical practices, policy and planning, and social community services. The reviews were prepared by distinguished gerontologists in nursing, law, surgery, psychology, pharmacy, social work, and other fields. The following topics are examined: (1) immunopathology of aging; (2) aging and basal ganglion functions; (3) ethnicity and aging; (4) age changes in sex roles amid changing sex roles; (5) bereavement and grief; (6) behavior therapies; (7) drug treatment of cognitive impairment; (8) aging and drug therapy; (9) alcoholism and over-the-counter and prescription drug misuse in the elderly; (10) past and future directions in gerontological nursing research; (11) aging, retirement, and the economic security of the elderly; (12) the state of practice in long-term health care planning; (13) conceptual and methodological issues concerning subjective well-being; and (14) diagnosis and treatment of urinary incontinence. (CI) (AgeLine Database, copyright 1984 AARP, all rights reserved)


OBJECTIVE: To assess the relationship between ethnicity and Health Care wishes, including Advance Directives, in a group of frail older persons in PACE (Program For All Inclusive Care Of The Elderly). DESIGN: Retrospective chart review of 1193 participants in the PACE program. SETTING: Program of All Inclusive Care Of The Elderly (PACE), a comprehensive managed care demonstration program serving frail older participants at 10 sites across the nation. PARTICIPANTS: A total of 1193 older adults, all of whom met state criteria for nursing home level of care. There were 385 non-Hispanic whites, 364 blacks, 156 Hispanics, and 288 Asians. MEASUREMENTS: Presence or absence of advance directives, type of health care wishes selected including living will, durable power of attorney, and health care proxy. RESULTS: Frail older white, black, Hispanic and Asian Americans differ significantly in their health care wishes and how they choose to express them. Blacks were significantly more likely to select aggressive interventions and less likely than non-Hispanic whites and Hispanics to utilize a written instrument for expressing health care wishes. Whites were significantly more likely to utilize written documents for advance directives, whereas Asians were more likely to select less aggressive interventions but were unlikely to use written advance directives. CONCLUSIONS: In this population, we found significant ethnic variations in choice of health care wishes. Although health care wishes are an individual decision, an awareness of cross cultural patterns can assist practitioners in addressing the concerns of their patients, as well as assisting Health Care Policy Development.


This is a retrospective study using secondary data to investigate variation in site of death by ethnicity and to determine how hospice enrollment affects site of death. Data for this study were obtained between 1996 and 2000 from linked Medi-Cal and Medicare claims from 18 California counties participating in a state legislated effort to improve chronic care services in California. Subjects examined in this study included 38,519 decedents aged 65 and older who died between 1997 and 2000 and were dually eligible the entire year immediately before death. Demographic variables were site of death, cause of death, hospice use, and care setting in the year before death. Results revealed that blacks and Latinos were significantly more likely than whites to die at home, although being black or Asian was negatively associated with hospice use. This variation did not change when hospice use was
controlled. Thus, although minorities were more likely to die at home, they were less likely to receive hospice care. Because patients dying at home without hospice care report higher rates of pain than those who have hospice care, physicians must work to ensure that minority patients understand all end-of-life care options, including hospice, and how these care options can be delivered in a culturally competent manner.


This paper critically examines criteria for equitable, effective, and efficient health care and explores theoretical propositions about how these three components of health care affect health outcomes and patient satisfaction. Findings from four studies with older, low-income immigrants and minorities, including Chinese and Russian immigrants, U.S.-born African Americans, and a non-immigrant, non-minority comparison group of Caucasians are presented. Critical analyses suggest that (a) equity, effectiveness, and efficiency must operate as a triad to improve health outcomes, and (b) patient satisfaction is not necessarily related to effectiveness and efficiency. This article is an adapted version of a keynote address at the 12th Annual Primary Care for the Underserved Conference held May 2004 in Fort Lauderdale, FL.


Describes several projects designed to increase cultural competence within palliative care, focusing on the ethnic Chinese population in Calgary, Canada. A collaborative effort was undertaken with the Regional Palliative and Hospice Service within the Calgary Health Region, the Capital Health Area's Palliative Care Program, and the Calgary Chinese Elderly Citizens' Association to identify and translate commonly used assessments and other tools into languages used by the Chinese community. A community workshop was held to educate older Chinese about palliative care and hospice and to get their input on assessments and translation issues. The translated assessments and other documents included the Calgary Interagency Pain Assessment Tool, Edmonton Symptom Assessment Scale, a palliative care services brochure, a consumer questionnaire, and a consent form. Individual evaluation and group discussion of the translated documents by community members was positive and provided helpful feedback. (MM) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Examined the palliative care needs of older adults in Australia from a non-English-speaking background (NESB). All inpatient files at the Sacred Heart Hospice (SHH) in Darlinghurst were reviewed for the period October 1994 to September 1997, yielding a total of 3,078 admissions, 414 of which were for NESB individuals. NESB patients were born in 74 countries, with the largest numbers from Greece, Italy, the former Soviet Union, Hungary, and China. A focus group was conducted with health professionals from the SHH and representatives of 4 NESB communities—Greece, Italy, the former Soviet Union, and China. A number of specific strategies aimed at providing a more culturally sensitive health care service to individuals from an NESB were identified. These include building stronger relationships with ethnic communities, sponsoring events for the NESB community, hosting orientation days targeting NESB health professionals, and improving communications with people from an NESB. (MM) (AgeLine Database, copyright 2002 AARP, all rights reserved)

*No abstract available*


The Chinese community in the UK is the fourth largest ethnic group in the UK, yet its health care needs are frequently overlooked by policy makers and planners when allocating funds for specialist service provision. Andrew Foong and colleagues report the findings of a study into the knowledge and perceptions of primary mental health services among elderly Chinese people in one UK city that found most were not satisfied with the services of which they were aware, and were unaware of other statutory and voluntary services that might help them. Might the solution be specialist regional centres to meet this population’s particular cultural needs and expectations?


Diabetes knowledge in a multi-ethnic population was assessed in 161 insulin treated diabetic patients using a 21-point multiple choice questionnaire translated into the appropriate languages. Our data showed a significant difference in diabetes knowledge related to ethnicity, being less in Asians and Afro-Caribbean groups compared to Caucasians. In all groups there was a negative correlation with age, with older adults achieving lower scores. Gender and duration of disease did not appear to influence knowledge scores. This information has implications for the way in which we deliver our diabetes educational programme to ethnic minority groups and the elderly.


This paper examines the cultural appropriateness of the current service delivery practices in the Lower Mainland for the Chinese population, as Chinese seniors make up 40% of all visible minorities in Canada. The current service delivery practice is the person-centred approach. This paper examines the Western and Eastern cultural implications of personhood, the key concept in person-centred approach. A qualitative study conducted at S.U.C.C.E.S.S. Simon K. Y. Lee Care Home analyzed the experiences of health care professionals implementing a person-centred approach - Eden Alternative, is described. The study uses qualitative description to understand the meaning of the five participants’ firsthand experiences. Three ideas emerged: 1) the Eden Alternative is appropriate to the Chinese population, 2) the implementation of Eden Alternative needs to be modified to cater to the Chinese culture, and 3) the Eden Alternative is a process no matter the culture. The two implications of the study are: 1) health care professionals need to focus on who the person is in order to be truly person-centred, and 2) the responsibility is on the health care professionals to figure out how to provide optimal care to each senior.

OBJECTIVE: Despite much evidence showing racial disparities in the use of surgical procedures, it is unknown whether ethnicity affects perception of surgical risk. METHODS: We surveyed 1609 patients undergoing primary hip or knee replacement surgery. Relevant covariates including demographic data, body mass index (BMI), sex, comorbidities, education, and ethnicity were recorded. Pain and joint functional status were assessed at baseline and at 1-year follow-up with the Western Ontario McMaster University Osteoarthritis Index (WOMAC) pain and function scores. Risk perception was assessed with 3 survey questions. RESULTS: Non-European patients had greater functional disability and pain prior to surgery and demonstrated significantly greater perception of risk than European patients (p < 0.001). Independent of other covariates, non-European ethnicity was an independent predictor of a greater perception of risk (p < 0.05). CONCLUSION: Patient ethnicity is an important factor to consider in understanding a patient’s perception of risk in joint replacement surgery.


Examined the extent, determinants, and consequences of ethnic identification among older Chinese immigrants in British Columbia, Canada. At-home interviews were conducted during 1995-1996 with a random sample of 708 foreign-born Chinese adults aged 65 and older (median age 75) who were living in Greater Vancouver and Greater Victoria. Nearly one-half of the respondents (49.3 percent) reported that they thought of themselves as more Canadian than Chinese, 36.6 percent thought of themselves as more Chinese than Canadian, and 14.1 percent felt equally Chinese and Canadian. In logistic regression analyses, the strongest variable associated with the retention of Chinese ethnic identity was place of residence: respondents living in Victoria were nearly three times more likely to view themselves as more Chinese than were respondents in the Vancouver suburbs. Respondents who only spoke "some English" were nearly twice as likely to feel Chinese as those who spoke English well. Individuals who had a monthly income of more than $1,000 were about twice as likely to identify as Chinese as those with a lower income. More recent immigrants and those aged 75 and older were also more likely to view themselves as more Chinese. In general, those who retained a Chinese ethnic identity assessed their lives, their social supports, and their health as lower than that of their counterparts who identified less as Chinese; this relationship was particularly strong among women.


Examined the role of living arrangements in the quality of life of community-dwelling Chinese older adults residing in Vancouver and Victoria, British Columbia. A random sample of 830 persons aged 65 and older (median age 74) completed interviews in their own homes in the language of their choice. Data were analyzed for married or widowed respondents: 235 married men (mean age 73.3), 181 married women (mean age 72.2), and 320 widows (mean age 80.3). Ordinary least squares regression analyses were performed on well-being and life satisfaction for the three groups, and comparisons were tested for significance by chi square and the Levene test. Few differences were found for married persons, especially women. For widows, living alone significantly reduced quality of life in a number of areas. Living arrangements were not a significant predictor of life satisfaction or well-being for married men or women. For widows, living arrangements determined well-being but not life satisfaction. Age, health status, and social support were better predictors of quality of life for older Chinese Canadians than were living arrangements. Findings highlight the importance of empirically distinguishing marital status and living arrangements in studying the quality of life of older adults, not homogenizing older Chinese Canadians with regard to living arrangements, and focusing on older Chinese widows who live
alone as a group at risk of low well-being. (AR) (AgeLine Database, copyright 2000 AARP, all rights reserved)


Evaluated generational dissonance and well-being among middle-aged and older adults of Chinese and European descent living in New Zealand. A total of 283 participants aged 40-79 with adult offspring completed questionnaires: 100 (mean age 63.7) of Chinese descent and 183 (mean age 61.7) of European descent. Questionnaires included the Concerns About Aging scale, Geriatric Depression Scale-Short Form, General Subjective Well-being scale, World Health Organization's quality of life measure, and measures of generational dissonance in communication, financial hardship, and spirituality. Results showed that Chinese parents perceived greater generational dissonance than European parents. Greater generational dissonance was associated with more concerns about aging. For Chinese participants, but not European participants, generational dissonance predicted poorer subjective well-being. Greater generational dissonance was also associated with depression in Chinese respondents. The results challenge overidealized views of Chinese families and encourage a greater recognition and response to the potential information and service needs of Chinese families in Western nations. (AR) (AgeLine Database, copyright 2003 AARP, all rights reserved)


**Executive Summary:** “... The sample of 82 Mandarin-speaking newcomers was highly educated. The majority of them had university or tertiary education. The study found that the newcomers experienced such settlement difficulties and needs as: linguistic and communication barriers, problems in obtaining employment, discrimination, familial conflicts, psychological adjustment problems, isolation, and housing problems. In terms of their access to social and community services, the newcomers reported inadequate access to information, accessible and appropriate ESL classes, health care, subsidized childcare, services for seniors, and youth activities. The participants suggested programs to assist them in obtaining employment, recognition of their foreign credentials and employment experience, ESL classes for professional and highly skilled newcomers, accessible information on community and social services, specialized assistance for ESL students applying for university, increased services in the Mandarin and Mandarin-speaking newcomers. . . . “


Examines the place of culture and social structure in understanding caregiving in minority ethnic groups, using studies undertaken in Quebec, Canada, with Haitian, Italian, and Chinese families. Results indicate that practitioners should base their practice on the following principles: analyzing the caregiving dynamic within the context of specific values and beliefs of the family and their socioeconomic conditions and the general sociopolitical context, not overestimating the importance of cultural factors at the expense of structural factors in the assessment of needs, and focusing not only on cultural differences and specificities but also on what is similar for all families. It is argued that true cultural competence situates cultural differences within the socioeconomic context of the groups in question and within the larger picture of dominant social relations. It is concluded that if health care and social service practitioners do not adopt a more structural approach, they run the risk of reducing problems confronting caregivers of minority ethnocultural groups to “ethno-specific” problems and of
excluding these groups when considering fundamental issues and problems facing all caregivers. (AY) (AgeLine Database, copyright 2004 AARP, all rights reserved)


No abstract available.


Discusses experiences recruiting Chinese American older adults and their caregivers into a cross-cultural qualitative study of dementia caregiving. Provides an overview of the social process of dementia-label avoidance among Chinese Americans and the cultural tendency for Chinese communities to stigmatize both the individuals and their families if a mental illness such as dementia becomes publicly known. Discusses the authors' retrospective qualitative interviews with 16 Chinese American caregivers who were recruited into their cross-cultural study of dementia caregiving as well as an analysis of field notes based on another 14 Chinese American caregivers. Notes that interview transcripts and field notes were content analyzed for evaluative clauses and for idioms and illness labels used by caregivers to describe dementia-related symptoms; interviews with Chinese American health care providers and notes taken during recruitment interviews with individuals who refused participation were also content-analyzed. Identifies a process of dementia-label avoidance engaged in by both Chinese American families and health care providers and discusses how this process can interfere with the recruitment of Chinese American participants into studies of mental illness. Suggests such strategies to enhance recruitment of Chinese American participants as inviting gatekeepers and providers to participate in the research and making assurances about confidentiality. (SW) (AgeLine Database, copyright 2000 AARP, all rights reserved)


Examined the validity of the factor structure of the original Radloff's (1977) Center for Epidemiologic Studies-Depression Scale (CES-D) for an older Chinese immigrant population. The CES-D was administered to 76 Chinese immigrants aged 50-86 (median age 80) via telephone interviews. The confirmatory factor analysis results did not support the original four-factor theoretical structure but did suggest a three-factor model. In addition, the three-factor version showed high internal consistency among the subscales. This revised CES-D reflected differences in the manifestation of depression in the Chinese participants. (KM) (AgeLine Database, copyright 2001 AARP, all rights reserved)


No abstract available


Analyzed mental health service utilization by older Asian and Pacific Islander Americans. The Andersen and Newman model of health services utilization was used as a conceptual framework for organizing and analyzing variables that predict service use. Data were supplied by the Automated Information System maintained by the Los Angeles County Department of Mental Health. Data included utilization, service, and clinical information for 600,000 adults and children who entered the Los Angeles County mental health system between 1973 and 1988. A sample of 496 Asian and Pacific Islander Americans aged 50 and older (mean age 60.0) who used inpatient or outpatient services was analyzed. The sample included 102 Chinese, 97 Japanese, 71 Koreans, 104 Pacific Islanders, 62 Filipinos, and 60 Vietnamese; 56 (11 percent) utilized inpatient services and 440 (89 percent) utilized outpatient services. Compared with the other ethnic groups, Vietnamese clients were more likely to be treated for adjustment disorders; were far less likely to be referred into treatment by health agencies compared with family, friends, and social agencies; had more sessions of outpatient treatment; and were less likely to end treatment prematurely. Older Chinese, Japanese, Filipinos, and Koreans were most commonly treated for depression and were most often referred by social and health agencies. Illness severity as well as financial coverage significantly influenced the use of mental health services by all groups. Findings suggest that special mental health outreach programs may be necessary to facilitate the psychosocial adjustment of the Vietnamese, the most recent Asian group to immigrate to the United States. References are provided. (AR) (AgeLine Database, copyright 1996 AARP, all rights reserved)


Provides an outreach program to help families understand Alzheimer's disease (AD) intended for use by organizations that serve Asian American and Pacific Islander American families. Each program kit contains a videotape of seven 5-minute vignettes, each of which is directed toward a particular ethnic group and explains in a culturally appropriate and sensitive manner the characteristics of AD, its relationship to aging, and the importance of seeking both a physician's assessment and more information about AD. Each vignette uses actors of the featured ethnic American group who were selected for their bilingual skills. A booklet written in the featured group's native language accompanies the vignettes and provides more information about AD, including the national Alzheimer's Association's toll-free number for locating the nearest chapter office. The kit contains booklets in Cantonese, Ilocano, Korean, Samoan, Vietnamese, and English. Also included in the kit is an instruction card on how to access SAGEline, an audiotext service that provides information on AD topics by touch-tone telephone. Strategies for successful use of the model program include establishing an advisory group, recruiting and training members of the ethnic group or groups to serve as AD resource persons, and using the tools produced by the AD project. A sample agenda for a group presentation is provided. (AS) (AgeLine Database, copyright 1998 AARP, all rights reserved)

The goal of this retrospective pilot study was to provide a naturalistic description of the decision-making process regarding dementia, a chronic illness. The hypothesis was that in-depth descriptions by caregivers in a community setting would provide a more comprehensive and realistic representation of decision-making in the case of chronic illness than has been provided by most models. Data were gathered from in-depth, qualitative interviews with seven Chinese-American families living in the Boston area and caring for an elderly family member with dementia. These were supplemented with interviews with medical professionals and ethnography done in the community regarding the care of elders with dementia. Based on the findings, this paper proposes a dynamic, more comprehensive model for the social process of decision-making which is particularly applicable to clinical and life situations of decision-making in the case of chronic illness. The model describes: 1) the decision-maker constellation, including multiple family members, professionals and service systems; 2) relationships between decision-makers as "allies" or "competitors"; 3) variations in the nature of the decision-making process; and 4) the interaction of decision-making with larger social, economic and cultural forces. Decision-making in the case of dementia is placed within the conceptual framework of the "social course" of chronic illness.


Understanding variability in conceptions of dementia in multiethnic populations is important to improve care and guide research. The objectives of this study were to describe caregiver conceptions of dementia using a previously developed typology and to examine the correlates of conceptions of dementia in a multiethnic sample. This is a cross-sectional study conducted in Boston and the San Francisco Bay area. Participants were a convenience sample of 92 family dementia caregivers from four ethnic/racial groups: African-American, Anglo European-American, Asian-American, and Latino. In-depth, qualitative interviews explored the caregivers' ideas about the nature and cause of dementia (i.e., explanatory models). Explanatory models of caregivers were categorized as biomedical, folk, or mixed (folk/biomedical). Quantitative analyses examined the association between ethnicity and other caregiver characteristics, and explanatory model type. Overall, 54% of caregivers, including 41% of Anglo European Americans, held explanatory models that combined folk and biomedical elements (i.e., mixed models). For example, many families attributed Alzheimer's disease and related dementias to psychosocial stress or normal aging. Ethnicity, lower education, and sex were associated with explanatory model type in bivariate analyses. In multiple logistic regression analysis, minority caregivers (P<.02) and those with less formal education (P<.02) were more likely to hold mixed or folk models of dementia. Although minority and nonminority caregivers often incorporated folk models into their understanding of dementia, this was more common in minority caregivers and those with less formal education. Further research on cross-ethnic differences in a larger, more-representative sample is needed.


**SUMMARY:** The diagnosis of dementia often occurs well after the onset of the disease. Studies of help-seeking behavior may help illuminate why delays occur. **SPECIFIC AIMS:** (1) To describe pathways to diagnosis from the perspective of family caregivers and (2) to compare help-seeking patterns and experiences across three ethnic groups. **METHODS:** Semi-structured qualitative interviews were conducted with 39 ethnically diverse family dementia caregivers. Interviews were coded for help-seeking events (initial help-seeking, referrals to secondary helpers, and site of final diagnosis), pathway types, and adverse experiences within the healthcare system along pathways to diagnosis. **RESULTS:** Help-seeking was most often initiated by family members or formal care providers (ie, healthcare
providers or social workers), usually in outpatient primary care settings but also elsewhere (eg, social service agencies, hospitals). "Secondary" formal helpers were often involved, usually through self-referral by families rather than by healthcare providers. While most families reported receiving a "final" diagnosis, a small minority of predominantly Chinese-American families did not. Four distinct pathways to diagnosis were identified and found to vary significantly (p < 0.03) across the three ethnic groups, which we label as smooth pathways, crisis events pathways, fragmented pathways, and dead-end pathways. Adverse experiences in the healthcare system were common and included unsatisfactory diagnosis disclosure and explanation, inadequate workup, uncaring or insensitive attitude, language barriers, and discrimination. CONCLUSIONS: Cross-ethnic differences were found in both pathway types and in adverse experiences.


The National Institutes of Health is making efforts to increase the representation of minority elders in aging research. While it is often noted that cultural barriers may make the recruitment of minority elders into research more difficult, relatively little empirical exists to support this claim. The purpose of this study was to identify sociocultural barriers to recruitment that emerged during a four-year study of dementia caregiving among Chinese families in the Boston area. More specifically, this paper examines how culturally shaped conceptions of health, aging, and dementia impacted the recruitment process. This paper is based on a qualitative analysis of interviews with 23 Chinese families and extensive fieldnotes generated by project ethnographers and interviewers. The following themes emerged in this analysis: 1) dementia-related changes were construed as a normal part of the aging process rather than a disease, making it more difficult to identify dementia-affected elders and to recruit families, 2) research participation was viewed as potentially harmful because it can lead to excessive worry 3) Alzheimer's disease carries a social stigma among Chinese, leading families to shun formal diagnosis and research participation, and 4) practitioners viewed research as an intrusion offering no direct benefit to participants.


This paper is a qualitative study based on retrospective, unstructured, qualitative interviews with Mrs. Jones and other African-American, Chinese-American, Irish-American and Latino family caregivers in the Boston area. A narrative approach is used to show how family caregivers draw on their cultural and personal resources to create stories about the nature and meaning of illness and to ask how ethnic identity may influence the kinds of stories family caregivers tell. Three different story types are identified and described, each with a distinctive configuration of illness meanings and overarching theme, or storyline: a subset of African-American, Irish-American, and Chinese-American caregivers told us stories about Alzheimer's as a disease that erodes the core identity of a loved one and deteriorates their minds; a subset of Chinese caregivers narrated stories that emphasized how families managed confusion and disabilities, changes ultimately construed as an expected part of growing old; a subset of Puerto Rican and Dominican families, while using the biomedical label of Alzheimer's disease or dementia, placed the elder's illness in stories about tragic losses, loneliness, and family responsibility. To construct their stories, caregivers drew upon both biomedical explanations and other cultural meanings of behavioral and cognitive changes in old age. Their stories challenge us to move beyond the sharp contrast between ethnic minority and non-ethnic minority views of dementia-related changes, to local clinics and hospitals as sites where biomedical knowledge is interpreted, communicated, discussed, and adapted to the perspectives and lived realities of families.

*No abstract available*


Explored Chinese Canadian female caregivers' feelings about providing care for a relative with Alzheimer's disease (AD). Using an adapted version of the conceptual model of AD caregivers' stress by Pearlin and colleagues (1990), the authors conducted in-depth interviews in Cantonese with 12 caregivers aged 30-80. Qualitative analysis was inductive and done manually. Despite anticipating and accepting their caregiving role as a cultural obligation, these caregivers, like most caregivers, felt overwhelmed, anxious, and fearful of the future. Against their stated cultural and personal values, all caregivers had made applications to nursing homes, and 6 were ready to institutionalize their relatives when a place became available. While coping mechanisms and social support appeared to mediate their stress, participants' concerns about the influence of Western culture on traditional values and, in particular, intergenerational issues regarding caregiving provided an added burden. (KM) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)


Research indicates that minority caregivers use fewer outside social and medical services than white, European-American caregivers. Qualitative research has shown non-caregiving stressors stemming from family and community environments as affecting burden and service use among minority caregivers. Yet few studies of caregiver service use include multiple groups of minority caregivers, or quantitatively evaluate the influence of non-caregiving stress. Using Pearlin, Mullan, Semple and Skaff's (1990) model of caregiver stress, we examined the relationship of ethnicity, non-caregiving stressors, and other stress-associated variables to service use by African-American, Chinese, and Latino caregivers. A group of white, European-American caregivers served as a reference group. Results show ethnicity, non-caregiving stress, and the dementia-affected elder's impairment level to predict unmet service need. The results also point to the usefulness of a new measure of non-caregiving stress in evaluating service use among minority caregivers. [ABSTRACT FROM AUTHOR]


OBJECTIVE: To assess the relationship between ethnicity and decision-makers expressing healthcare wishes in a group of frail older persons enrolled in the Program of All-inclusive Care for the Elderly (PACE). DESIGN: A retrospective chart review of 1193 participants in the PACE program. SETTING: Program of All-inclusive Care for the Elderly, a comprehensive managed care demonstration program serving frail older participants at 10 sites across the nation. PARTICIPANTS: A total of 1193 older adults, all of whom met state criteria for nursing home level of care. Three hundred were non-Hispanic whites, 364 were black, 156 were Hispanic, and 288 were Asian. MEASUREMENTS: Demographic characteristics of the patients and the presence or absence of an alternative decision-maker; the characteristics of alternative decision-makers included the relationship to the participant as recorded in the patient's medical record. RESULTS: Ninety-one percent of white patients expressed their own
healthcare wishes in contrast to only 85% of Hispanic, 83% of Asian, and 67% of black patients. An
alternative decision-maker was identified for about 15% of Asians and Hispanics and for one-third of
blacks, but only about 8% of whites had an alternative decision-maker. Black and Hispanic patients
were most likely to have a daughter as an alternative decision-maker, Asians were most likely to have a
son, and whites patients were most likely to have a spouse as an alternative decision-maker. Blacks,
particularly black men, were the most likely to have a relative other than a spouse or child as an
alternative decision-maker. CONCLUSIONS: In this population, we found significant ethnic variation in
the person identified to be the decision-maker in a group of frail older people. Ethnic variation
reflected sociodemographic as well as cultural differences. However, there are important limitations to
this study, and caution should be used in extrapolating the results to other populations or in
attributing the results to ethnicity alone. An awareness of cross-cultural patterns in identified or de
facto decision-makers can be significant for healthcare workers when they approach patients and their
families about issues surrounding end of life decisions.

ethnic groups. *Dementia and Geriatric Cognitive Disorders, 22*(1), 42-47.

BACKGROUND/AIMS: Research on dementia among ethnically diverse populations in the USA has
focused primarily on Alzheimer disease and vascular dementia, but there are limited data on other
neurodegenerative causes of dementia. METHODS: To determine the frequency of neurodegenerative
disorders in four ethnic groups, data collected at Alzheimer’s Disease Research Centers of California for
assessments between 1992 and 2002 were analyzed retrospectively. Cases of Alzheimer disease,
vascular dementia, dementia with Lewy bodies, frontotemporal lobar degeneration, Parkinson disease
and progressive supranuclear palsy were identified for 452 Asian and Pacific Islander, 472 Black, 675
Latino and 4,926 White patients. RESULTS: The percentage of non-Whites diagnosed as having
dementia with Lewy bodies was lower than that of Whites. Frontotemporal lobar degeneration was as
common in Asians and Pacific Islanders compared to Whites, but less common in Blacks and Latinos.
Progressive supranuclear palsy was more frequent in Asians and Pacific Islanders compared to Whites,
but equally common in Blacks and Latinos. CONCLUSION: Additional study is needed on the social and
biological factors that influence the diagnosis and prevalence of non-Alzheimer and nonvascular
dementias among diverse ethnic groups.

UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

It is estimated that by 2025 the Asian population in the United States will be over 40 million; it will
represent nearly 10% of the total U.S. population. Currently Chinese immigrants are the largest Asian
group and constitute 22.6% of all Asian immigrants. With the Chinese immigrant population growing
steadily, the Chinese elderly population will increase in the future. Historically, "Hsiao" (filial piety in
English), rooted in Confucianism, teaches Chinese people to pay respect to living parents and provides
rules for culturally defined intergenerational relationships and family caregiving, and putting family
needs above individual interests. Among the Chinese, family caregiving is perceived as a duty,
obligation, responsibility, and cultural virtue. The purpose of the study was to test a theoretical model
specifying how factors including subjective beliefs of traditional filial obligation, subjective feelings
about role requirements, perceived burdens, perceived rewards and use of coping affect Chinese
caregivers’ health in the United States. The aim of this study was to understand how caregivers’
cultural background and the appraisal of family caregiving affect caregivers’ well-being. Data from 137
caregivers were used to describe sample profile and for model testing. The original model failed to
explain the data adequately. Two revised models were developed. Results suggest that data fit better
with physical health, as indicated by CFI = .91 and the chi2/df ratio = 2.9, than mental health model, as
indicated by CFI = .90 and the chi 2/df ratio = 3.5. Findings suggest caregivers' beliefs of traditional filial
obligation is a primary predictor for caregivers' physical health. Caregivers' subjective beliefs of
traditional filial obligation affect caregivers' physical health not only directly but also indirectly.
Implications for nursing research, practice, education and theory construction, and policy making were
addressed. Limitations and recommendations for research design and interpretation of model fit were
described. Further studies are needed to compare differences in cultural influences among different
ethnic groups, identify effective coping style and test the effect of intervention caregivers' health.

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82. Huang, L. (2007). Chinese culture versus Western medicine: health implications for San Francisco elder
Chinese immigrants with heart failure. UMI Dissertation Services, ProQuest Information and Learning,
Ann Arbor, MI.

The purpose of this ethnographic study was to explore cultural beliefs of elder Chinese immigrants
toward Western medication regimens as few studies were conducted in this area. Hypertension among
erder Chinese immigrants is a growing problem in San Francisco with its leading complication of heart
failure. This study was designed to reveal any cultural variables that may promote or interfere with
medication adherence in the elder immigrants in San Francisco. Six participants with a history of heart
failure were recruited from a clinic in San Francisco. Cultural views were obtained based on data from
observation and interviews and grouped into specific categories by software NUDIST with analysis
under the guidance of Johnson's behavioral system model and social epidemiological concepts. This
study explored inter and intracultural factors that might enable or hinder Western medication
adherence behavior. The study found Western medication adherence in elder Chinese immigrants with
heart failure can be affected by traditional Chinese and adapted beliefs from U.S. migration toward
acute and chronic disease management. This study lends itself to social change by documenting the
problems of inadequate communication between Western and Chinese practitioners and emphasizing
the critical importance of integration through understanding and utilization of traditional as well as
adapted Chinese cultural values. Biases of the study included the convenience and small sample size.
As a further step toward social change, the study suggested the importance of future research on
Western medication adherence in different geographically located subcultural group of elder Chinese
immigrants with heart failure. (Author Abstract, used by permission) (AgeLine Database, copyright
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British Columbia, Canada, has emerged as a popular settlement area for Chinese and Korean
immigrants. Responding to the demographic trend, the goal of this study was to examine current
characteristics of housing and neighborhoods and utilization of local amenities of Chinese and Korean
seniors in BC in exploring the possibility of aging-in-place in their home and community. The data were
collected using face-to-face interviews for 99 participants (50 for Chinese and 49 for Koreans). To
compare group differences between Chinese and Koreans, chi-square and t tests were conducted.
Results indicated that Chinese and Korean seniors stayed at current housing about 10 years and did
not plan to move out in the next 3 years. However, Chinese seniors were more likely to live with their
adult children and church was an important resource for Korean seniors. Local amenities created more
resources and social support for both Chinese and Korean seniors, but Chinese seniors tended to
actually use various local amenities more than Korean seniors. To Korean seniors, ethnic Korean
church was an important source of community links. The role of housing should be discussed from a
bigger context to enable the participants to remain in their familiar environment.

Previous studies that have focused on Asian American intergenerational relationships used the cultural concept of filial obligation to explain an adult child's commitment to his/her elderly parents. Using data gathered from 628 Chinese, Japanese, and Korean Americans and their elderly parents, this study found that such financial and structural factors as an adult child's income and his/her parent's need for assistance significantly influenced the frequency of an adult child's support for his/her parents. The effects of filial obligation on an adult child's provision of support for his/her parents change depending on several of these financial and structural factors. The magnitude of these relationships varies, however, among three groups of Asian Americans. It is therefore necessary to examine interaction effects of cultural, financial, and structural factors on Asian American intergenerational relationships as well as the diversity of these relationships within the Asian American population.


Because most successful interventions for Alzheimer’s disease (AD) rely upon early diagnosis and implementation, it is important to understand the factors influencing dementia treatment-seeking behaviors. These include perceptions, beliefs, values, and feelings relating to AD, which may vary among and within ethnic groups according to the strength of culturally-based explanatory models and individual group members’ ages and experiences. This study used ten focus groups drawn from Asian American communities representing different national origins (Chinese, Japanese, and Korean) to examine the factors shaping attitudes toward AD in general, and treatment-seeking in particular, that may constitute barriers to timely diagnosis and treatment of AD among Asian Americans of various ages and cultural backgrounds. The results suggest that, while these communities share a keen awareness of AD, beliefs regarding the disorder may be influenced at least as strongly by folk wisdom and culturally acceptable partial truths as by scientific information.


Outlines the demographic and sociocultural characteristics of the diverse Asian American and Pacific Islander groups and examines their mental health needs. Reviews the immigration history of various Asian American groups, including Filipinos, Asian Indians, Koreans, Japanese, Chinese, and Vietnamese. Delineates the rapidly changing sociodemographic characteristics of these groups. Discusses methodological issues in defining and measuring mental health status. Examines existing studies of mental health status of Asian Americans in general and elderly Asians in particular. Explores the nature and characteristics of underutilization of mental health facilities among Asian Americans. Recommends ways to enhance their utilization of mental health services, including language, ethnicity, and gender matches between clients and service professionals and an improved understanding by professionals of culturally based differences in perception, cognition, evaluation, and expression of mental disorders in their Asian American clients. Discusses directions for future research on the mental health of older Asian Americans. Includes references. (AR) (AgeLine Database, copyright 1996 AARP, all rights reserved)

Increasingly evident is the important role of partners in patients' adaptation to diagnosis, treatment, and recovery. Yet, little is known about partners' adaptation when patients reach the benchmark known as long-term survival. This study describes elderly wives of prostate cancer survivors' perspectives of adaptation to the enduring challenges of prostate cancer survival and considers their experience in the context of ethnicity. Content analysis and grounded theory methods guided data collection and analysis of two waves of in-depth interviews with 26 elderly Asian/Pacific Islanders (Chinese, Filipino, Japanese, Native Hawaiian) living in Hawai‘i. Continuous learning was the most common phenomenon as reflected in four types of adaptive work: involvement in husband’s health, affirmation of the marital bond, normalization of adversity, and participation in personally meaningful acts. Issues are highlighted for consideration in developing culturally relevant, age-appropriate, and strengths-based interventions.


This study examines the relationship between ethnicity and the provision of assistance to older relatives. A sample of employed Canadians (N=2,753), a subsample of the CARNET Work and Family Survey, is used to explore how ethnicity influences the amount of assistance provided to older relatives. Findings from our study suggest that Asians, East Indians, and Southern Europeans provide higher levels of help than British respondents. Filial obligation affects the amount of help provided but plays a similar role within each ethnic group. However, structural factors - in particular, living arrangement and age - are stronger predictors of the level of involvement in helping older relatives than are cultural factors of filial obligation and belonging to a particular ethnic group.


BACKGROUND: It is unclear whether race/ethnicity influences survival for acute critical illnesses. We compared hospital mortality among patients of Asian (originating from Asia or Southeast Asia), Native Indian, and European descent admitted to the ICU. METHODS: Prospective cohort study of patients admitted to three ICUs (January 1999 to January 2006) in British Columbia, Canada. Multivariable analysis evaluated hospital mortality for each ethnic group, adjusting for age, sex, APACHE (acute physiology and chronic health evaluation) II score, hospital, median income, unemployment, and education. To account for differences in case mix, multivariable analysis was also restricted to those patients admitted for the five most common ICU admission diagnoses (sepsis, pneumonia, brain injury, COPD, and ARDS) and adjusted for these diagnoses. RESULTS: Of 7,331 patients, 21% were Asian, 4% were Native Indian, and 75% were of European descent. Crude mortality was 33% for Asian, 30% for Native Indians, and 28% for patients of European descent. After adjusting for potential confounders, Native Indian descent was not associated with an increase in mortality compared to European descent. Asian descent was associated with a significantly higher mortality (odds ratio [OR], 1.22; 95% confidence interval [CI], 1.06 to 1.41; p = 0.005). After adjusting for case mix, this difference was no longer seen. For patients admitted for COPD exacerbation, Asian descent was associated with a substantial increase in mortality (OR, 4.5; 95% CI, 1.56 to 12.9; p = 0.005). There were no significant differences in mortality by race/ethnicity for patients who had any of the other common admitting diagnoses. CONCLUSION: Patients of Asian and Native Indian descent with acute critical illness did not have an increased mortality after adjusting for differences in case mix.
Given the growing ethnic diversity in Canada, it is essential to recognize potential ethnic variability in acute myocardial infarction (AMI) symptoms to increase timely and effective treatment. We thus examined ethnic variation in symptom presentation and access to care of patients presenting to the emergency department (ED) with AMI. A random sample of 406 health records of Caucasian, Chinese, South Asian, Southeast Asian, and First Nations patients discharged from hospitals in the Calgary Health Region (Alberta, Canada) was audited. Measured variables were compared across ethnic groups and associations with classic AMI symptom profile and timely presentation to a hospital were examined. Chinese, South Asian, and Southeast Asian patients were 64% to 69% less likely than Caucasian patients to have a classic symptom profile reported and were less likely to speak English than their Caucasian and First Nations counterparts (p 12 hours to present to the ED; even in patients who presented with a classic symptom profile, South Asians were 70% less likely than Caucasians to report to the ED within 3 hours of symptom onset. Caucasians were significantly more likely to undergo angiography within 3 hours of presentation to the ED (42%, p = 0.001). In conclusion, explanatory variables associated with variability in symptom presentation and access to care associated with ethnicity require further exploration to ultimately develop effective strategies aimed at increasing timely presentation and care access.

A recent study of 830 Chinese seniors currently residing in Greater Vancouver and Greater Victoria (Chapell & Lai, 1996) found that health service utilization by this group is similar to that found among other groups of seniors in British Columbia and Canada as a whole. Predictors of service use were likewise parallel to that of other populations. Nonetheless, cultural factors were seen to be relevant insofar as traditional health care use was concerned. In order to explore these cultural facets of health care in greater depth, the Centre on Aging (out of which the original study was conducted) commissioned a much smaller qualitative study with an English-speaking subgroup of Chinese seniors from the same metropolitan areas. This report details the findings of this in-depth study.

First outlining the methodology used and characteristics of the sample, we go on to report findings in three broad, interdependent areas: (1) preventive health care; (2) local categories of disease etiology; and (3) treatment modalities. The themes reported under each section emerged from the data itself and into two broad domains (a) eating habits and (b) exercise and social activities. When asked to comment on causes of ill health, research participants again identified two main themes. The first of these details the relationship between mental and/or emotional distress - particularly as these relate to work and the family-and physical health. The second examines the nature of food - 'poisonous,' 'heating,' and 'cooling' - as identified in terms of the traditional Chinese concept of yin-yang. Finally, the section on health care looks at self-care and professional care, each of which can be subdivided into 'Western' and traditional Chinese treatments. Here we further explore some tentative relationships between health care utilization patterns and behaviours identified in previous sections (e.g. relative adherence to yin-yang philosophy).

Reuniting immigrant families has been considered an important goal in Canadian policy (Citizen and Immigration Canada (CIC), 2006). When an elderly relative is sponsored under the Family Class immigration category, the sponsor makes an unconditional undertaking of support for a period of ten years to the Minister of Citizenship and Immigration. This is a longer period than for any other Family Class group. In addition to their legal status as dependents, sponsored seniors—the majority from India and China—are left financially and socially vulnerable by a constellation of cultural, situational and structural factors. Based on case studies of the South Asian and Chinese immigrant populations by authors, Koehn and Hwang, and the legal expertise of author Spencer, we conclude that Canada’s laws and policies have an important effect on intergenerational tension, the senior’s status, social isolation, as well as the risk of abuse and neglect or domestic and workplace exploitation. These factors can influence access to essential services such as housing and health care services. While further evidence is needed, findings from preliminary studies indicate the need for policy-level revisions as well as other approaches to reducing the vulnerability of this significant subpopulation of ethnic minority seniors.


Objectives: This article critically reviews two decades of empirically based depression studies on older Asian immigrants (OALs) in North America published in English. The Psychosocial Model of Late-Life Depression is proposed as the conceptual roadmap to help interpret the findings across studies. Methods: Using multiple bibliographic databases, this review systematically summarized and evaluated findings in 24 studies in terms of: (a) the prevalence and severity of depression; (b) demographic, psychosocial, cultural, and health risk factors of depression; and (c) methodological approaches and designs. Results: The results showed that depression is prevalent among OALs and is linked to gender, recency of immigration, English proficiency, acculturation, service barriers, health status, relationship with children and family, and social support. However, considerable variability in the results, the sample sizes, and the use of measurements were also found across studies. Discussion: Recommendations for future research and the provision of clinical and community services are discussed within the psychosocial model. ABSTRACT FROM AUTHOR (Copyright of Journal of Aging & Health is the property of Sage Publications Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.)


Examined factors that affect the utilization of health care services and home- and community-based care (HCBC) programs by older Taiwanese in the United States. Data were drawn from the 1994 Southern California Taiwanese American Elderly Survey for a convenience sample of 240 Taiwanese aged 65 and older (mean age 74.5). Data were analyzed based on a modified Andersen behavioral model that included both cultural and structural variables. Approximately 16% of respondents had not visited a doctor in the past year, while 17% were hospitalized with an average stay of 1 day. Forty-six
percent of the respondents had attended a senior center, 39% ate in a congregate meal site, and 14% used transportation services. On the other hand, 35% never used any HCBC programs. Having arthritis and having children living in Southern California increased the likelihood of doctor visits 8-fold, while having poor health status increased the likelihood of doctor visits 3-fold. Having a lower education, having better English-speaking ability, having a heart problem, living alone, and having longer years of immigration in the United States increased the likelihood of hospitalization. Living alone and preferring services provided by professionals of the same cultural background increased the likelihood of using HCBC programs 5-fold and 4-fold, respectively. Having functional limitations, longer residence in the United States, and arthritis also increased the likelihood of HCBC utilization. (AR) (AgeLine Database, copyright 2000 AARP, all rights reserved)


Investigated the prevalence of depression among older Chinese adults in Canada. Ninety-six randomly selected members aged 65-88 (mean age 71.74) of a senior center in Calgary completed a telephone survey. A 15-item Chinese version of the Geriatric Depression Scale was used as the depression measure. Results showed that among the respondents, 9.4 percent were mildly depressed and 11.5 percent were moderately to severely depressed. In Canada, the estimated prevalence rate of depression among the general older population is close to 10 percent. Thus, even if those who were mildly depressed were excluded, the prevalence rate of 11.5 percent in this study is still slightly higher than the national estimate. It is concluded that contrary to the misconception that older Chinese adults have a lot of informal support and do not require professional services, the present results suggest that they have mental health needs similar to those of the general older population. (KM) (AgeLine Database, copyright 2000 AARP, all rights reserved)


Examined the prevalence of depression among a sample of Chinese older adults in Canada. Telephone interviews were conducted in October 1998 with 96 randomly selected members of the Chinese senior center in Calgary, whose memberships account for more than 77 percent of the estimated total of the older Chinese population in the city. The respondents were aged 65-88 (mean age 71.7) and completed a Chinese version of the 15-item Geriatric Depression Scale. It was found that 9.4 percent of the respondents had mild depression, while 11.5 percent experienced moderate to severe depression. Women reported higher levels of depression than men: 28.8 percent of the female respondents reported mild to severe depression, while the prevalence rate for males was only 10 percent. The prevalence of depressive symptoms reported by the older Chinese is twice that of the estimated prevalence among the general older adult population in Canada. (MM) (AgeLine Database, copyright 2000 AARP, all rights reserved)


Examined the factors explaining different types of senior center service use among a random sample of older Chinese immigrants in Calgary, Canada, using the Andersen-Newman service utilization framework. The random sample of 97 Chinese immigrants aged 54-91 (mean age 69.3) who use Calgary’s only Chinese senior center were interviewed in their native language about their general level of use of 19 types of services provided by the senior center, grouped into 4 categories (acculturation, recreation, task assistance, and support services). Predisposing factors were age,
gender, marital status, education level, living arrangement, place of origin, and length of residency in Canada; enabling factors were financial status and social support; and need factors were mental health, negative affect, life satisfaction, and self-perceived health. Results show that most of the respondents visit the senior center regularly, although support services are substantially underutilized. Findings also show that the predictors of use vary for different types of senior center services. While the use of acculturation services is predicted by age of the users, the use of recreation services is better explained by place of origin and negative affect. The use of task assistance services is best explained by gender, satisfaction with services, and negative affect. The use of support services is predicted by living arrangement, satisfaction with services, and fewer mental health symptoms. (SW) (AgeLine Database, copyright 2002 AARP, all rights reserved)


In an aging and culturally diverse society, medical professionals need to understand the health status of ethnic minority older adults. Data collected by questioning 765 randomly selected older Chinese-Canadians in Vancouver and Victoria were extracted from a multisite study for further analysis. The results show that the older Chinese-Canadians in Vancouver were less healthy than their counterparts in Victoria. The health discrepancies may be associated with several factors, including more service barriers, lower level of self-rated financial adequacy, and a less positive attitude toward aging.


This replication study measured the prevalence of depression and its related explanatory factors in a community sample of older Chinese Americans and examined the reliability and validity of the Chinese Geriatric Depression Scale developed by Mui (1996). Fifty-four Chinese Americans aged 59-95 (mean age 74.82) completed a revised version of the Chinese Geriatric Depression Scale (GDS) and SF-12 Health Survey. According to the cutoff scores suggested by the authors of the scale, 14.9% of participants had mild depression while 5.7% had moderate to severe depression. Internal consistency of the Chinese GDS was high, with a Chronbach's alpha of .88. The GDS scores correlated significantly with the Mental Component Summary of the SF-12. Reliability and validity of the Chinese GDS support the applicability of the instrument in measuring depression in older Chinese Americans. (MM) (AgeLine Database, copyright 2003 AARP, all rights reserved)


Lai seeks to examine the health status of the aging Chinese adults in Canada and compare it with the health status of the general aging population in Canada. Results of the study showed that older Chinese-Canadians reported better physical health than older adults in the Canadian population, while older Chinese in all age and gender groups scored lower on the mental component summary of the study.

Examined the health status of the older Chinese population in Canada and compared the health status of this group with that of the general aging population in Canada. Data were derived from the multisite Health and Well-Being of Older Chinese in Canada study (for 2,272 participants aged 55 or older) and the Canadian Multicentre Osteoporosis Study, which published Medical Outcomes Study 36-Item Short Form (SF-36) scores from the same age cohorts in the general Canadian population. Independent
samples t-tests were used to compare the statistical significance of the Chinese and general population groups. Overall, older Chinese Canadians reported better physical health than all older adults in the Canadian population. However, the older Chinese participants in all age and gender groups scored lower in the mental component summary, indicating poorer overall mental health in this population. Chinese women reported significantly poorer health than Chinese men in all of the 8 health domains. It is concluded that efforts to address the health needs of older Chinese Canadian women, the most vulnerable subgroup in this study, are essential, and interventions are also needed to address poor mental health status in this ethnic minority group overall. (KM) (AgeLine Database, copyright 2006 AARP, all rights reserved)


**OBJECTIVES:** The impact of culture on mental health has been inadequately researched. This study examines the effect of cultural factors on the depressive symptoms reported by elderly Chinese immigrants in Canada. **METHOD:** Data from 1537 elderly Chinese immigrants who took part in a cross-sectional multisite survey on the health and well-being of older Chinese-Canadians were used. Participants were identified through telephone screening of randomly selected telephone numbers listed with Chinese surnames. A structured questionnaire was used to conduct face-to-face interviews. A Chinese version of the 15-item Geriatric Depression Scale was used to assess depressive symptoms. **RESULTS:** Close to one-quarter of the elderly Chinese immigrants reported having at least a mild level of depressive symptoms. Having more cultural barriers and a higher level of identification with Chinese cultural values resulted in a higher probability of being depressive. **CONCLUSIONS:** The importance of the sociocultural determinants of mental health is demonstrated. The health delivery system should be more sensitive to the unique ethnic and cultural differences of older immigrants.


Examined predictors of use of long term care (LTC) facilities among older Chinese in Canada. Data were obtained from the Health and Well-Being of Older Chinese in Canada study on 2,272 adults aged 55 and older living in 7 major metropolitan areas. Among the 2,249 participants who answered the question on whether they would consider living in an LTC facility if their health deteriorated, 920 (40.9%) indicated that they would. Significant predictors of intention to apply to an LTC facility were higher levels of dependence in instrumental activities of daily living, living alone, higher levels of social support, and higher levels of Chinese ethnic identity. Living alone increased the probability of having an intention to apply to an LTC facility by 2.37 times. (MM) (AgeLine Database, copyright 2005 AARP, all rights reserved)


Examined the level and predictors of using selected home care services by older Chinese immigrants in Canada. Data were obtained on 1,537 Chinese immigrants aged 65 and older in regard to home care use, sociodemographic factors, Chinese health beliefs, social support, service barriers, and physical and mental health. It was found that 80 participants (5.2%, mean age 79.4) used home care services, while 1,457 (mean age 73.8) did not. Being older, living alone, having post-secondary education, immigrating from Hong Kong or Southeast Asia, having a high level of agreement with Chinese health beliefs, higher social support, and poorer physical and mental health were predictors of home care use. The probability of using home care services lessened with increased self-rated financial adequacy. The
results point to the need for service providers to address the gap in home care use among Chinese immigrants in Canada compared with other Canadians through promotion of appropriate use of home care services. (MM) (AgeLine Database, copyright 2005 AARP, all rights reserved)


Examined cultural factors and preferred living arrangements of aging Chinese in Canada. Data from a 2001-2002 national study of 2,272 Chinese Canadians aged 55 and older that included physical and mental health status, Chinese health beliefs and medicine, life satisfaction, and community support services were analyzed using logistic regression. Of the 2,053 respondents who indicated a living arrangement preference, 1,050 (mean age 69.7) preferred not living with adult children and 1,003 (mean age 70.0) preferred living with adult children. Potential predictors of preferred living arrangement were sociodemographic factors, health- and need-related factors (number of illnesses, functioning in basic and instrumental activities of daily living, physical and mental health, self-rated financial adequacy, and social support), and culture-related factors (religious affiliation, self-rated English competency, country of origin, length of residency in Canada, and identification with Chinese cultural values). When compared with those who preferred living with children, more who preferred not living with children were married, living alone, had a higher level of education, had a lower level of identification with traditional Chinese cultural values, had a western religion, and were born in Canada. Among the health- and need-related variables, no significant differences were reported in number of illnesses, and physical and mental health between the 2 groups. However, those who preferred living with children reported a significantly higher level of dependency on others in activities of daily living. The findings suggest that culture-related factors were more important predictors of preferred living arrangement than health- and need-related factors. (SW) (AgeLine Database, copyright 2005 AARP, all rights reserved)


Background: There is a lack of research regarding depression in older Taiwanese immigrants in North American countries. This study in Canada therefore examined the prevalence of depressive symptoms among older immigrants from Taiwan, and psychosocial factors as predictors of depressive symptoms reported by older Taiwanese immigrants. Methods: Ninety-eight migrants (aged ?? 55 years) from Taiwan to Canada, who were part of a multi-site study of health and well-being in a total of 2,272 older ethnic Chinese individuals in community dwellings, completed a face-to-face interview and answered questions in an orally administrated questionnaire. Depressive symptoms were measured by a Chinese version of the Geriatric Depression Scale. Results: Of the 98 migrants from Taiwan, 21.5% reported at least a mild level of depression. Predictive factors for depressive symptoms were a negative attitude towards aging, poor general physical health, single marital status, barriers in terms of gaining access to health care services, poor financial status, lower level of identification with Chinese health beliefs, and low income. Conclusion: The prevalence of depressive symptoms in older Taiwanese immigrants in Canada was higher than that reported by older adults in the general Canadian population. Thus, implications for the delivery of health care services, and possible strategies to enhance the mental well-being of older Taiwanese immigrants, are discussed

This study examined the prevalence and predictors of use of senior centers by a random sample of 1,537 elderly Chinese immigrants in Canada. A service utilization model of Andersen and Newman (1973) was adopted as the theoretical framework to examine the predicting effects of predisposing, enabling, and need factors. The findings showed that 28.8% of the elderly Chinese immigrants reported using a senior center within the past year. Having a religion, living alone, having stronger Chinese ethnic identity and stronger social support were the significant predictors identified, as shown in the hierarchical logistic regression findings.


For many aging people, living alone leads to many positive and negative implications for their well-being. In Chinese culture, in which strong family ties and values are emphasized, elderly Chinese living alone is not a common phenomenon. This study examined the differences between elderly Chinese-Canadian immigrants living alone and those living with others, and the role of living alone in their health and well-being. The findings showed that those living alone reported fewer limitations in instrumental activities of daily living and received a higher level of social support than those living with others. Women living alone were less mentally healthy than their counterparts. Policies makers and practitioners need to address the mental health needs of the elderly immigrant women in this vulnerable group. Programs and interventions should address the gender and racial oppression, and culturally unique needs for stronger family support.


This study examined the effects of filial piety on the appraisal of caregiving burden by Chinese-Canadian family caregivers. A quantitative telephone survey was used as the research design for this study. A total of 339 randomly selected Canadian-Chinese family caregivers of elderly were interviewed by telephone. A hypothesized model denoting both the direct and indirect effects of filial piety on caregiving burden was tested using structural equation modeling. While stressors and appraisal factors reported direct predicting effects on caregiving burden, filial piety indirectly affected caregiving burden by altering appraisals of the caregiver role. Filial piety served as a protective function to reduce the negative effects of stressors and to enhance the positive effect of appraisal factors on caregiving burden.


One common myth about ethno-cultural minority family caregivers is that they do not use formal services. This study examined the intention of using home support and long-term care facilities by a random sample of 339 Chinese-Canadian family caregivers, using a modified version of the Andersen-Newman service utilization model. Filial piety, caregiving burden, care receivers, and health conditions are the common predictors identified. Filial obligation is most likely manifested through facilitating the care receivers to make use of the services needed, particularly for caregivers who reported a high level of caregiving burden.

The authors examine the effects of service barriers on the health status of older Chinese immigrants in Canada. A survey was completed in seven Canadian cities by a random sample of 2,214 older Chinese immigrants age 55 years or older. Service barriers related to administrative problems, personal attitudes, and circumstantial difficulties were significant predictors of physical and mental health when controlling for the demographic factors. Empirically, the findings confirm that service barriers are detrimental to the health of older immigrants. The service barriers in the areas of ethnic, language, or cultural differences between the service providers or services themselves and the older Chinese clients also suggest that factors related to communication contribute to these older clients' perception of services or providers as culturally insensitive or unresponsive. Considering the individual, social, and economic costs incurred by adverse health consequences, barriers in service delivery must be addressed.


   No Abstract Available


Examined service barriers experienced by Chinese immigrant family caregivers in Canada and the predictors of different types of barriers. The 315 adults aged 18 and older providing care to 315 family members aged 65 and older (mean age 74.7) completed a telephone survey with a structured questionnaire regarding demographics, health status, caregiving tasks and burdens, impact of caregiving, depressive symptoms, caregiving rewards, caregiving attitudes, and service use and barriers. Age of caregivers was grouped into 7 categories ranging from 18-24 to 75 and older. Results of principle component and multiple regression analyses showed that financial factors significantly predicted the number and types of barriers reported by caregivers. Service barriers were grouped into 5 types: cultural incompatibility, administrative problems, circumstantial challenges, negative perception toward services, and personal attitude. Culture-related factors were significant in predicting the total number of access barriers and the different types of barriers experienced by the caregivers. The findings indicate the importance of culturally sensitive support for family caregivers to reduce the access barriers. (SW) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)


This study examined the relationships between culture and the health status of older Chinese in Canada. Data were collected through face-to-face interviews with a cross-sectional, randomly selected sample of 2,272 older Chinese between 55 and 101 years of age in seven Canadian cities. Health status was assessed by the number of chronic illnesses, by limitations in ADL and IADL, and by information on the Medical Outcome Study Short Form SF-36. Although cultural variables explained only a small proportion of variance in health status, having a stronger level of identification with traditional Chinese health beliefs was significant in predicting physical health, number of illnesses, and limitations on IADL. Other cultural variables, including religion, country of origin, and length of residence in Canada, were also significant in predicting some health variables. Interventions to improve health should focus on strategies to enhance cultural compatibility between users and the health delivery system.

Explored the life satisfaction of older Chinese immigrants living in a community in western Canada. Eighty-one respondents, 58 females and 23 males, aged 65-96 (mean age 76) were randomly selected from senior housing facilities for the Chinese in Calgary. Eighty of them had lived in Canada for 3 years or more, 61.7 percent were widowed, and 65.4 percent lived alone. Life satisfaction was measured by both the Life Satisfaction Index-A (LSI-A) and a single-item global measure of life satisfaction; both instruments were translated into Chinese. The LSI-A is a multidimensional measure assessing five components of life satisfaction: zest (versus apathy), resolution and fortitude, congruence between desired and achieved goals, positive self-concepts, and mood tone. Most respondents were rather satisfied with their life and scored high on the LSI-A; the mean score was 13.1 on a scale of 0-20. Activity level, general health, psychological health, social support, self-esteem, and sense of personal control were the significant variables associated with both satisfaction measures. Multiple regression analyses revealed that psychological health, social support, and sense of personal control were the strongest predictors of life satisfaction, with no significant difference observed between male and female respondents. It is concluded that to help older Chinese immigrants achieve a higher level of life satisfaction, adequate supportive resources should be developed and made accessible to them. (AR) (AgeLine Database, copyright 1995 AARP, all rights reserved)


Elderly people from ethnic minority groups often experience different barriers in accessing health services. Earlier studies on access usually focused on types and frequency but failed to address the predictors of service barriers. This study examined access barriers to health services faced by older Chinese immigrants in Canada. Factor analysis results indicated that service barriers were related to administrative problems in delivery, cultural incompatibility, personal attitudes, and circumstantial challenges. Stepwise multiple regression showed that predictors of barriers include female gender, being single, being an immigrant from Hong Kong, shorter length of residency in Canada, less adequate financial status, not having someone to trust and confide in, stronger identification with Chinese health beliefs, and not self-identified as Canadian. Social work interventions should strengthen support and resources for the vulnerable groups identified in the findings. Service providers should adjust service delivery to better serve elderly immigrants who still maintain strong Chinese cultural values and beliefs.


This paper reports on aspects of the subjective evaluation of perceived health status of aged Chinese-Canadians in Toronto. The survey data revealed that an extremely high proportion, 80.4% of respondents (N=140) were satisfied with their own health. Of the remainder, 13.7% were dissatisfied, 5.8% had mixed feelings. Are these aged Chinese respondents leading a life without much health problems? A closer examination of their apparent satisfaction reveals that ethnicity, the extent to which Chinese traditional health beliefs and practices can be sustained, and their self-defined appropriate role in a changed sociocultural milieu have great impact on their aging process and experience. The paper concludes that the combined effect of changing socio-demographic characteristics interfacing with their distinctive cultural traits about aging in a changed sociocultural milieu have significantly affected the self-assessment of their health status.
Examine factors related to depressive symptomatology in an elderly cohort of Chinese Americans living in a midwestern city with a relatively small Asian community. Forty-five members aged 59-89 of the Chinese Senior Citizens Society completed structured questionnaires that included the 30-item Geriatric Depression Scale, MMSE, Life Satisfaction Scale, Social Support Scale, a health status questionnaire, Activities of Daily Living (ADLs) Scale, Instrumental ADLs Scale, an occupational and economic status questionnaire, an acculturation scale (Anderson and colleagues, 1993), and a question to determine command of the English language. A high rate of clinically significant depressive symptomatology was found as 20.0 percent had a GDS score of 11 or above; 11.1 percent scored 15 or above. Life satisfaction, social support, health status, functional status, number of years present in America, level of acculturation, and command of the English language were all found to be inversely related to depressive symptoms. (TB) (AgeLine Database, copyright 1997 AARP, all rights reserved)

As more and more Californians are diagnosed with diabetes we see our communities facing the debilitating effects every day. With more than 1.8 million Californian adults diagnosed with the disease, diabetes has risen to the seventh leading cause of death in California and the leading medical cause of amputations, blindness, and kidney disease. However, the burden of diabetes is not equally distributed among all populations. Instead, California’s racial and ethnic minorities are experiencing higher prevalence rates and increased risk of diabetic complications compared to their White counterparts. In order to stem the increasing prevalence of diabetes and eliminate these growing disparities, the health field must work not only to create parity in the medical screening and management of the disease, but also to address the nutritional and physical landscapes of disadvantaged communities. It is only by acknowledging the context in which diabetes develops and progresses that we can begin to address the root causes placing communities of color at elevated risk for diabetes.

Describes the development of community-based health services for minority elderly in the Chinatown area of Boston, Mass. In the 1960s, the Chinese American Civic Association (CACA) sponsored a forum that resulted in a task force being developed to address health care and other concerns of the Chinatown population. The CACA movement to address social service and health care needs included the establishment of the South Cove Community Health Center (SCCHC), a storefront operation that gradually expanded and became more comprehensive. Many Chinese immigrants continue to practice various forms of traditional Chinese medicine, and these traditional beliefs can act as cultural barriers to health care services in this country. Other barriers to health care are economic and language difficulties and poor communication between hospital staff and community physicians. In the early 1980s, the SCCHC initiated efforts to improve the accessibility and quality of health care for the elderly in the community. SCCHC activities include a Living at Home Project that attempts to link social services and health care through case management. Areas that remain to be addressed are discussed. (LS) (AgeLine Database, copyright 1989 AARP, all rights reserved)

Presents results of a survey questionnaire of health service workers in ethnically diverse communities concerning the delivery of health services to the elderly in their respective communities. The survey respondents were 371 health workers (average age 42) from six communities in Australia: Anglo, Arab, Chinese, German, Greek, and Italian. The majority of health workers represented were nurses (16 percent), followed by workers on health projects, community health workers, nurses’ aides, welfare workers and counselors, health interpreters, social workers, and volunteers. Significant differences were found in the evaluation of 15 of 18 aspects of health services, which included seven mainstream services, four evaluations of health care providers, and seven ethno-specific services. Of the six communities, two—the Chinese (68 percent) and the Greek (63 percent)—gave the highest average ratings of satisfaction with mainstream health services. The ratings of the Arab, German, and Anglo respondents were similar (59 percent), while the Italians were reported to be the least satisfied with mainstream services. Ethno-specific services, such as the helpfulness of health interpreters and the availability of doctors speaking ethnic languages, were most satisfactory among the Arabic-speaking community, followed by the Chinese, Greek, Italian, and German communities. Results show that communities with a shorter history in Australia tended to value services more highly. (TS) (AgeLine Database, copyright 1994 AARP, all rights reserved)


**Executive Summary**: The purpose of this pilot study was to examine the experiences of a group of Chinese immigrant women who provided care to their aging parents and the experiences of the parents who received the care. The cultural dimensions and immigrant experiences of the care-giving dyad was explored. In particular, we examined the experiences of the dyads living in three generational household, a common practice in the Chinese culture. This study was based on in-depth interviews with nine care givers and recipients (18 respondents). We used a semi-structured interview schedule to explore the feelings and the challenges faced by the dyads in care-giving and how this was coloured by the immigration process.

Our findings indicated that the care-giving experience of women in three generational households can be a burden only when the care recipients are frail, and ill. Otherwise, the care-giving and receiving experience was not in one direction; rather it was reciprocal, this is especially so when the elderly parents were healthy and able. This reciprocal characteristic reflects the cultural traditions in the Chinese family system.

We also found that the mobility, independence, and the total life cycle of these elderly Chinese immigrants were affected by language barriers, transportation barriers, isolation, lack of culturally and linguistically sensitive health and social services, making care-giving especially challenging. The immigrant women who cared for frail elderly parents themselves faced additional challenges due to factors resulting from immigration, such as weak informal social networks, and the lack of culturally and linguistically sensitive health and social services.

On the other hand, the helping hands of the elderly parents lessened some of the struggles in settling in a new country mostly for the women and especially for those who had to participate in the work force to sustain the family. It was concluded that the inter-dependence between the generations assisted in the adaptation process to immigration for the whole family. Implications of the findings were discussed.
Assessed Chinese American women’s views of health and illness and the potential influences of culture and language on cancer screening behavior. Participants were 54 Chinese women aged 52-82 (mean age 65) residing in the Washington, D.C., metropolitan area, where there is a high concentration of Chinese Americans and Chinese organizations. Focus groups, each consisting of 9-12 women and lasting for 1-2 hours, were held at 2 local Chinese churches and 3 senior centers. Participants' perceptions of health and illness, cancer knowledge, beliefs about and barriers to cancer screening, and screening and health care experiences were explored. Participants considered outdoor exercise in the morning for fresh air and a hot-cold balanced diet as important means to health. None mentioned the importance of regular medical checkups or cancer screening. When talking about cancer prevention, a sense of fatalism was evident in participant responses, such as "no control of life and death" and "what will happen will happen." Lack of English capability was a major enabling barrier to utilization of health care services. In addition, these women reported the need for help with transportation, especially those living in suburban areas where public transportation was not readily available. Physician recommendation was identified as the most important reinforcing factor for cancer screening. The results suggest traditional Chinese beliefs influence the perceptions of older Chinese women regarding health, illness, and the use of preventive care.
a health study of Asian Americans in selected regions of the country. (LS) (AgeLine Database, copyright 1986 AARP, all rights reserved)


The main question of this dissertation is "how to understand aging service use levels by Asian/Chinese seniors?" Four service use theoretical models/frameworks and previous studies were used as guides to derive possible service use explanatory components and factors in understanding service use by Asian/Chinese seniors. This study intends to explore and identify those factors, components, and their interrelationships which explain service use by Asian/Chinese elderly. A community-based case study was used as the tool to achieve the research goals. The Capital District of New York is the research site. Twenty-nine Chinese seniors living in the Capital District, ten Chinese community leaders and ten aging service officers/providers are the research respondents. Semi-structured interviews were conducted to gather information from all research respondents. This study used information gathered from the research respondents for data analysis. The data analysis is to determine whether the proposed explanatory factors and components relate to service by the elderly respondents, and how these components and factors interact and shape the service use outcomes. The main conclusion of this study is that service use by Chinese elderly respondents can be understood as the outcomes of the interactions among the explanatory components proposed. Specifically, this study found relationships between three of the explanatory components (individual characteristics, mainstream aging service characteristics, and community/other helping resources characteristics). The relationships are explained through match/mismatch and/or substitution relationships among the explanatory components. When there is a match, the elderly respondents perceived the needed service as available, accessible, acceptable, and they use the service. When there is mismatch, the elderly respondents do not perceive the needed service as available, accessible, or preferred/accepted, and they do not use the service. In addition, substitution relationships occur when there are other helping resources available. These other helping resources may substitute for the use of mainstream aging services, even if there is a match relationship between individual and mainstream aging service characteristics. The findings of this study can be used as the analytic approach to understand aging service use levels by Asian/Chinese elderly as well as other elderly groups. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Explored the need for and use of aging services among subgroups of older Chinese Americans. A convenience sample of 13 male and 16 female Chinese Americans aged 60 and older completed face-to-face semi-structured interviews. Using qualitative data analysis, 4 subgroups were identified, based on immigration status, occupational status history, family characteristics, and language and driving ability: 9 retired professional families, 6 young and middle-aged nonprofessional immigrants (immigrated in their 20s to early 50s and have been in the United States for a long period of time), 8 older recent immigrants (immigrated in their 60s and 70s and have been in the United States less than 10 years), and 6 older long-time immigrants (immigrated at age 60 or older and have been in the United States more than 10 years). Typical need and use patterns characterized most respondents within each subgroup. Older recent immigrants perceived themselves as having great needs for affordable health insurance, transportation assistance, social/recreational activities, and improvement in their English ability; however, they did not use the mainstream aging services that they needed. Older long-time immigrants generally had needs for housing, transportation, and financial assistance, but did not use the mainstream aging services that they needed. Retired professional family
respondents did not perceive themselves as having service needs and reported not using services. Findings point to the importance of looking at subgroup variation in aging-service needs and uses within a population. (AR) (AgeLine Database, copyright 2004 AARP, all rights reserved)


A Chinese Dementia Specialist Education Program (CDSEP) was launched in the Greater Boston Area to educate Chinese American health care providers who lacked adequate dementia education and services. This program trained bilingual health care providers to identify, assess and serve people with dementia and their families, and raised dementia awareness in Chinese American communities. The ten-month follow-up survey documented that the sixteen graduates helped over 70 families and held 76 workshops and formal and informal discussions, reaching over 400 people. The CDSEP demonstrates that a “Train the Trainer” model is an effective approach for building dementia care capacity in community-based agencies, increasing outreach to people with dementia and their families, and for raising dementia awareness in bilingual and minority communities.


Chinese American elders are one of the fastest growing ethnic minority groups in the US, and more research is needed to describe their health status and services. The purpose of this descriptive, cross-sectional survey was to describe health services (dependent variable) in relation to health status, barriers to health services use, and the demographics (independent variables) of Chinese American elders. A health services use conceptual framework was used to organize the variables. Three main characteristics in the model: predisposing, perceived enabling resources and barriers to health services utilization, and perceived need characteristics were measured by a group of variables. They were: age; gender; years staying in the US; education; living alone; English fluency; location; family income; health insurance coverage; knowledge, access, and intent barriers; and the Iowa Self Assessment Inventory, which measures seven facets of the health of the elders. The health status of Chinese American and Anglo-American elders was compared. Snowball sampling method was used and 945 subjects were recruited from September to December 2000. Four hundred and sixty-seven (467, 49% of total surveys) completed questionnaires were returned and analyzed. Descriptive statistics were used to describe the health status and services use of the subjects. The variance in health services use explained by the framework variables was analyzed by multiple regression statistics. Female Chinese American elders were disadvantaged and used less health services by less education, less health insurance coverage, less English speaking, and more living alone. Physical health was the most important predictor of health services use. A bimodal pattern was found for the socioeconomic status of Chinese American elders. Health insurance coverage and mental health status were significantly positively correlated with health services use for poor Chinese American elders. Among Chinese American elders with higher family incomes, education level was positively correlated with services use, and disbelief in Western health services was inversely related to services use. Chinese American elders had better perceived health status than Anglo-American elders in this study. Implications for practice, education, research, and policy; and the limitations of the study are discussed. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Gender and ethnic differences in personal health practices were examined with a sample of 1021 Medicaid recipients aged 65 years and older. Six different health practices were examined including smoking, drinking, weight control, exercise, and social networks. Although gender differences were noted with respect to all of the health practices examined, neither men nor women were consistently favored in adhering to desired health practices. Perhaps most importantly, women were more apt than men to refrain from smoking and drinking which have been strongly linked to major health consequences. Ethnicity was also a factor in all of the health practices examined. Whereas Hispanic and Black elderly were very similar to White elderly, Asian elderly generally adhered to more desired health practices than did either Whites, Blacks, or Hispanics. The implications of these findings could benefit health promotion programs for the elderly.


This paper documents varying patterns of support service use by Chinese and Caribbean seniors, living in social housing managed by the Toronto Community Housing Corporation (TCHC). It explores the factors that facilitate more extensive use of support services and programs critical for the continued independence and well-being of seniors. It argues that structural factors beyond individual characteristics affect patterns of support service use. These include:

- A critical mass of tenants with a similar racial background living in the same building;
- Closeness to a institutionally complete ethnoracial community; and
- The intervention by social or community case workers.
- The findings have broader policy implications for the pattern of support service use for other ethnoracial minority seniors in other metropolitan areas.

132. Luo, R. (2002). Development and testing a chronic disease health beliefs and lifestyle practices questionnaire for older Chinese Americans. UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

A survey health questionnaire was translated into Chinese and tested to assess chronic disease knowledge (CDK), health beliefs, and lifestyle practices among 97 Chinese Americans, 55 and older. Hypotheses on age, gender, acculturation, socioeconomic status, health status, and health behaviors were tested. Pearson’s correlations revealed that education, past occupation, getting by in the U.S. were positively related to CDK partially. Gender, health status (summary), and health behaviors (summary) were not related to CDK. Total family income, age, length of stay, communication, health insurance coverage, and barriers were inversely related to CDK partially. Further MANOVA tests also confirmed that age group differences on CDK. In the future, further analysis of these complex patterns will be conducted because they are outside the scope of this exploratory study. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Examined the role of cognition and psychiatric status in treatment nonadherence among older adults. A total of 212 ethnically diverse primary care patients aged 55 and older (mean age 67.8) completed the Mattis Dementia Rating scale (DRS), Geriatric Depression Scale (GDS), and Beck Anxiety Inventory (BAI). Treatment adherence was assessed by the number of missed health care appointments and by physician and patient ratings. Physician ratings of patients’ understanding of medical instructions were
also obtained. GDS and DRS memory scores were both independent predictors of the total number of missed medical appointments. GDS scores were a significant predictor of physician ratings of patients' understanding of medical instructions. Neither cognitive performance nor psychiatric status was associated with patient or physician ratings of treatment adherence. Results suggest that measures of cognitive functioning and depression severity functioned as predictors of objective measures of treatment adherence but they were not associated with physician or patient ratings of adherence. Patient depression may influence physician ratings of patients' comprehension of medical instructions.


Explored the incidence and documentation of cognitive impairment (CI) among older adults with severe mental illness (SMI) in a community mental health setting. Data were collected from 52 ethnically diverse adults aged 56 and older (mean age 69.4) with SMI who were receiving treatment at a large community mental health center; 61% lived independently, 28% lived in board and care facilities, and 12% lived in supportive centers for older adults. CI was diagnosed by neuropsychologists using the Mattis Dementia Rating Scale-2 (DRS). Measures of depression severity and substance abuse history were also obtained. An age- and education-corrected DRS total score falling at or below the tenth percentile was used as the criterion for diagnosing CI. A medical chart review was conducted to determine the documentation of CI among this population. Results showed that CI was exhibited by 60% of adults and documented in medical charts for 17% of them. Preliminary data suggest that CI is common in adults with SMI being treated at community mental health centers, but is not well recognized or documented.


Assesses access to social and health services for older people of different ethnic groups at three community and social service centers (CLSCs) in Montreal, Canada. Reviews current perspectives on institutional racism in Canada and on institutional discrimination against ethnic elders. Presents data on the ethnic origin of Montreal’s older population. Describes a case study that compared social services provided by CLSCs for older people in two ethnic communities (Portuguese and Chinese) with services for the elderly of the two dominant cultures (French-Canadian and English-Canadian). Data were collected in interviews with community workers, social workers, and a nurse. Older individuals from French-Canadian, English-Canadian, and Portuguese communities appeared to enjoy complete access to CLSC services. Older Chinese, on the other hand, did not have services or material about those services in their native language and did not have a firm commitment from the provincial government that services would continue from year to year. Concludes that institutional racism is part of social and economic relations in Canada.

The prevalence of depression among immigrant Chinese elderly occurs at a higher rate than the larger population (Radloff, 1997; Yu, 1986; Ying, 1988). The severity of the disorder leads to high rates of suicide in this population (Yu, 1986). Thus, the need for effective treatment, prevention and assessment is great. The low rate of utilization of mental health services has been historically noted for all Asian populations (Hatanaka, Watanabe, & Ono, 1975; Lin, Lin, 1978; Loo, Tong, True, 1989; Sue, & McKinney, 1975; Sue, & Morishima, 1982). Many barriers, such as cultural stigmas of mental illness, social perceptions of Asians as not vulnerable to psychological stressors, and low access to social services are noted to exist (Leong, & Lau, 2001; Sue, & McKinney, 1975; Sue, & Morishima, 1982). Detection and treatment typically does not occur until the symptoms are exacerbated and inpatient treatment is required (Surgeon General, 2001; Tsai, Teng, & Sue, 1981; Lin, et al. 1978; Lin, & Cheung, 1999). Thus, the need for culturally appropriate and effective instruments to assess the nonpatient population of immigrant Chinese elderly is essential. One instrument commonly used to assess depression is the Beck Depression Inventory. Before proceeding with the literature review and the findings of this study, 3 terms--immigrant, elderly, and depression--need to be defined. (1) Immigrant. The term immigrant is used to define a person or group of people who are not native born to the country in which they currently reside. In this study the immigrant Chinese person is one who may have been born in mainland China, Taiwan, or Hong Kong. (2) Elderly. Elderly in this study is defined as 60 years of age or older because all participants in the archival data are members of a community based senior center that require a minimum age of 60. (3) Depression. The standard definition, as identified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), for depression will be used when referring to the clinical manifestation and diagnosis of the disorder (DSM-IV; American Psychiatric Association, 1980). (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2005 AARP, all rights reserved)


**Objective.** To better understand DTSM by the elderly, including non-English speaking elderly, after discharge from a rehabilitation facility. Design. A convenience sample, non-experimental, exploratory study. **Method.** Patient chart reviews; home visits employing a structured questionnaire, medication review, and semi-structured interview. Result. Twenty-one patients (16 English-fluent; 5 Cantonese-fluent) participated. Participants demonstrated: self-determination in advocating for themselves; judgment concerning the legitimacy of prescribed drug therapy; knowledge about their disease and medication; and/or acceptance of DTSM as part of their lifestyle. Most found DTSM activities to be easy, except for monitoring signs/symptoms of disease and drug effects; inadequate/ineffective communication with health care providers was a contributing factor. Mobility, a DTSM activity-related function, was difficult only for some Cantonese-fluent participants because of early discharge precipitated by language problems. **Conclusion.** Elderly rehabilitation-discharged patients are generally confident and effective in DTSM. Language and culture influence medications used, provider selection, and institutional adaptation. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

Over the past decade, municipalities around Greater Vancouver have witnessed an ever-increasing multicultural mix. This mix is evident in the school system, in municipal parks, and in local shopping centres. But the same multicultural representation is not evident in the clientele of many community services, for example services for seniors. This report describes findings from a study which examined suburban immigrant seniors’ awareness and access to health and community services. The report also profiles other aspects of immigrant seniors lives and makes a number of recommendations for improving their quality of life. The study consisted of two hundred and fifty interviews, with 50 seniors (25 males and 25 females) from each of the Punjabi, Portuguese, Korean, Cantonese and German speaking communities. Participants were 55 years or older and were presently residents of Burnaby, New Westminster, Coquitlam, Port Coquitlam or Port Moody. The directive for the study was community development; thus, the report has been prepared with local organizations' needs and concerns in mind. For the same reason, the presentation of statistics in the body of the report has been minimized.


Provides a review of the literature on the health of the older Asian and Pacific Islander American (APIA) population. Examines the demographic and historical background of the APIAs, focusing on the Chinese, Japanese, Filipino, Korean, Asian Indian, Southeast Asian, and Pacific Islander segments of the group. Discusses the mortality and morbidity of the APIA population, reviewing research on specific conditions (such as cancer, hip fracture and osteoporosis, and infectious disease) and specific ethnic groups. Presents studies that focus on the use of health care services by the APIA population, access and barriers to care, the role of family and social support in health care, and ethical issues. Summarizes some of the health beliefs and practices of the APIA population, focusing on the specific health beliefs and practices of specific ethnic groups. Discusses the implications of the reviewed research in regard to future research, ethnogeriatric care, and ethnogeriatric education. Includes references. (MM) (AgeLine Database, copyright 1998 AARP, all rights reserved)


Discusses the importance of recognizing ethnic and racial differences in bioethical decision making. The value placed on individual, autonomous, informed decision making in the United States is not shared by cultures in which family members have a filial responsibility to make decisions for the patient. Health care providers must find ways to accommodate cultural differences and show respect for patients' cultural contexts. The first step in this process is to recognize difference and to be curious rather than judgmental about it. Cultural differences may exist in time orientation, privacy, expression of pain, roles of family members, willingness to engage in dialogue, and the meaning of gifts. Problems may occur in using family members as interpreters, particularly when family members want to shield the patient from information about a poor prognosis. If patients choose to have decisions made by the physician and the family, informed consent can be delegated to family members. Patients from other cultures should not be viewed in isolation but within the context of relationships that lend meaning to their identity. Examples are cited from Native American, Chinese, Mexican, Korean, and Italian cultural approaches to medical decision making and the physician-patient relationship. (PH) (AgeLine Database, copyright 1995 AARP, all rights reserved)

British research on the quality of life in old age has neglected the increasing ethnic diversity of the older population, and although studies of health and income inequalities have highlighted the contribution played by racism, analyses of the factors influencing the quality of life have rarely considered its effects. This paper discusses inequalities in quality of life among older people from different ethnic groups using data from a cross-sectional survey of 203 White British, Asian, Black Caribbean, Black African and Chinese people aged 55 and more years living in England and Scotland. They were interviewed face-to-face in the language of their choice using a semi-structured schedule. Consistent with the existing literature, the study found differences in health, income and social support among the ethnic groups. The paper suggests, however, that future work should examine disparities in health and income within as well as between minority ethnic groups, and that a greater appreciation is required of the way in which such disparities may be accentuated by variations in health expectations, in the distribution of income within households, and in the willingness to discuss financial difficulties. The cumulative effects of health and material disadvantage and the experience of racism have implications both for future quality of life research and for government policies that aim to raise social inclusion and reduce inequalities.


Presents a working paper on the health of Asian/Pacific Islander elders living in the United States and its territories, with information on demographics, morbidity, mortality, barriers to care, and health practices and beliefs. The Asian/Pacific Islander category includes more than 20 different ethnicities with little common ancestry, culture, or language. This analysis focuses on elders from Chinese, Japanese, Filipino, Korean, Southeast Asian, Samoan, Guamanian (Chamorro), and Tongan backgrounds. Some data were drawn from the 1980 census, although information is limited in many areas; other data were drawn from the literature. It was found that place of birth is an important variable affecting mortality rates, with death rates for foreign-born Chinese almost six times higher than those reported for American-born Chinese. For the 10 leading causes of death, mortality rates at all ages for foreign-born persons were at least two times the rate for American-born Chinese, Japanese, and Filipinos across all ages. Pacific Islanders were found to be at risk for diseases associated with obesity, including cardiovascular disease, hypertension, and adult onset diabetes. The Chomorros had an unusually higher prevalence rate of two neurologic diseases--amyotrophic lateral sclerosis and Parkinsonism dementia. Asian/Pacific American elders visited office-based physicians half as often as white Americans of the same age group; however, they had the highest rate of use of emergency room services of any ethnic group. Factors limiting access to care included language difficulties, lack of funds, location of services, and psychological barriers. Although Western medicine is practiced in Southeast Asian cultures, particularly for the relief of symptoms, there is also a reliance on traditional medicine and self-care practices that are relevant to belief systems. Nursing home residence rates in this population are low. References are provided. (UH) (AgeLine Database, copyright 1993 AARP, all rights reserved)


Studied the relationship between the level of acculturation and functional impairment among older Chinese and Vietnamese residents of San Diego, California. Participants were 50 persons of Chinese origin aged 45 and older (mean age 71) and 50 persons of Vietnamese origin aged 45 and older (mean age 61). They completed an instrument eliciting information on demographic characteristics;
residential, medical, occupational, and educational histories; housing; nutritional risk; Alzheimer’s disease risk factors; depression; and attitudes toward and use of alcohol. Functional impairment was measured with the assessment portion of the Older Americans Resources and Services instrument, and acculturation and cultural assimilation were evaluated with two measures comprised of seven scales. There were significant differences in the prevalence of functional impairment between older Chinese and Vietnamese, and between gender and age groups within each of these two ethnic groups. Levels of acculturation and structural assimilation were identified as major contributors to variations in degree of impairment between and within the groups. Three findings are highlighted: both groups exhibited substantially high prevalence and levels of economic resource and physical health impairments; the highest prevalence and levels of impairment were found among females and persons over age 60, regardless of ethnicity; and statistically significant associations were found between levels of functional impairment and levels of acculturation and assimilation, and these associations were not confounded by the effects of low income status or years since migration. Vietnamese data generally revealed fewer associations between acculturation and level of impairment, suggesting that the larger community acted as a buffer for these elders. There were strong indications that improvement in English language skills would have positive effects on all dimensions of functional impairment for both sets of immigrants. (UH) (AgeLine Database, copyright 1992 AARP, all rights reserved)


Montgomery County in Maryland is one of the most ethnically diverse regions in the United States. Since the 1970s, traditional American and Kosher meals have been offered at congregate sites in this County, but few seniors of varied ethnicity participated. This article describes creative approaches used in the County Senior Nutrition Program within the Older Americans Act from 1990 to 2007 to develop nutrition sites targeted to seniors in Korean, Vietnamese, and Chinese communities. The services provided are culturally sensitive, and the meals meet both nutritional and food safety standards. With secure funding, programs can be made available to other ethnic groups.


Examined the relationship between living arrangement and depression among older Chinese immigrants in a major metropolitan area. The 147 cognitively intact respondents aged 62-99 lived with others (112, mean age 73.2) or alone (35, mean age 75.5). A Chinese language questionnaire was developed to assess sociodemographics, informal support system, self-rated health status, and stressful life events; depression was measured with the Chinese language Geriatric Depression Scale. Almost one-third of Chinese immigrants living alone were 80 and older, and more than half of them were widowed. About 68 percent of respondents living alone were women, were somewhat better educated, and had longer length of stay in the United States. Most, regardless of living arrangement, spoke Chinese only; only a few knew English. Those who lived alone had significantly more depressive symptoms than those living with others (5.9 versus 3.7). Results show that those who lived alone had higher levels of education, reported poorer health, experienced more stressful life events, and were dissatisfied with help received from family members were more likely to be depressed. Social workers helping this group need to consider these variables in designing culturally appropriate mental health interventions for older Chinese immigrants. (SW) (AgeLine Database, copyright 1999 AARP, all rights reserved)

Describes an exploratory study conducted in New York to assess the service needs and the services currently provided to older Asian Americans. Eighteen Asian American social services programs completed a mailed questionnaire that focused on service need, service provision, service requests, agency board characteristics, staffing characteristics, and funding sources. For comparison purposes, 140 mainstream human service organizations and senior programs known to provide services to older Asian Americans participated in a brief interview. Findings revealed that clients were primarily women, aged 70 and older, receiving Supplemental Security Income benefits, and living with family. Most met needs were tangible and facilitative rather than clinical. Services needed but not provided were emergency psychiatric care, home attendants, home-delivered meals, legal services, medical services, and protective services. The services provided were comprehensive in scope, if not in access. There was a match between the services the experts perceived as needed (normative needs) and those that the older clients and their families requested (expressed needs). Despite this match, however, normative needs remained unmet and client perceived needs were undetermined. Several implications for social service providers are reviewed. (AG) (AgeLine Database, copyright 1999 AARP, all rights reserved)


This study examines the association between acculturation stress and depressive symptoms in a regional probability sample (n = 407) of six groups of Asian immigrant elders (Chinese, Korean, Indian, Filipino, Vietnamese, and Japanese). Findings suggest that about 40 percent of the sample were depressed, indicating higher depression rates than found in other studies of older American or Asian elderly samples in the United States and Asia. Multiple regression analyses indicated that acculturation stress caused by elders’ perception of a cultural gap between themselves and their adult children was associated with high depression levels. Other predictors of depression were poor perceived health, stressful life events, religiosity, proximity of children, assistance received from adult children, and longer residence in the United States. Data suggest that depression is prevalent among urban Asian immigrant elders and that there is great heterogeneity among Asian ethnic subgroups. Implications for social work practice are discussed.


This study examined the association between English language proficiency and health outcomes in a regional probability sample (n = 205) of elderly Chinese and Korean immigrants. Data support that these two Asian ethnic subgroups differ in English proficiency and health-related quality of life. Chinese and Korean elders had poorer health than the national norms, and poor English proficiency was associated with poorer outcomes for six of eight health outcomes measures. Implications for health care delivery and social work are discussed.


Provides an overview of the more commonly held values and beliefs among Chinese older adults in order to facilitate culturally appropriate health care. Before implementing actions based on the client's Chinese ethnicity, the health care provider must assess the client's individual background and association with being Chinese. Some common practices among Chinese include using family titles that identify specific people, such as "paternal aunt, first born"; using the last name first; respecting older
people; maintaining an ethnocentric view; using cultural symbols that represent long life, happiness, financial prosperity, and good luck; giving money as a gift; expressing criticisms, but privately; valuing frugality, politeness, education, harmony, and balance; practicing tai chi; using holistic care and self-care; and appreciating food that is a unified whole and seasoned perfectly. Specific recommendations are provided to help health care workers relate to their Chinese clients. (AS) (AgeLine Database, copyright 1999 AARP, all rights reserved)


OBJECTIVE: We sought to explore whether the elderly are high users of complementary and alternative medicine (CAM), and to determine which modalities they use. We also sought to describe patterns and positive predictors of CAM use among 3 ethnically diverse groups of community-residing elderly.

DESIGN: A 7-page questionnaire was developed and translated into Spanish and Vietnamese.

PARTICIPANTS: A population of 525 community-residing elderly completed personal interviews.

RESULTS: Two hundred and fifty-one respondents (47.8%) reported using CAM over the past year. Dietary supplements (47.4%), chiropractic (16.3%), home remedies (15.9%), acupuncture (15.1%), and Oriental medicine (12.8%), were the most frequently cited therapies. The majority of CAM users (62.4%) did not inform their physicians that they were using it, but 58% consulted their physician for the same problem for which they used CAM. Family and friends were most relied upon for making the choice of therapy. Among the 3 ethnic groups studied, Asians were higher users of acupuncture (28%) and Oriental medicine (31%), Hispanics were higher users of dietary supplements (56%), home remedies (25%), and curanderos (8%), while white non-Hispanics were higher users of chiropractic (42%), massage (20%), vitamins (20%), diet (17%), and psychospiritual (15%) modalities. Pain was a higher indicator of CAM use among Asians, gastrointestinal problems and diabetes among Hispanics, and stress/fatigue and cardiovascular problems among white non-Hispanics. CONCLUSION: Findings indicated a high use of CAM among the elderly and emphasize the likelihood that elderly immigrants use those therapies with which they are familiar. Modalities and conditions varied with the ethnicity of respondents.


*No Abstract Available*


The purpose of this ethnographic study was to understand how immigrant women caregivers accessed support from community resources and identify the barriers to this support. The study included 29 Chinese and South Asian women caring for an ill or disabled child or adult relative. All experienced barriers to accessing community services. Some possessed personal resources and strategies to overcome them; others remained isolated and unconnected. Family and friends facilitated connections, and a connection with one community service was often linked to several resources. Caregivers who failed to establish essential ties could not initiate access to resources, and community services lacked outreach mechanisms to identify them. These findings contribute new understanding of how immigrant women caregivers connect with community resources and confirm the impact of immigration on social networks and access to support.

Examines the impact of race and ethnicity on aging in Canadian society, focusing on inequalities and cultural constructions of differences. Discusses the ethnic dimensions of aging in Canada and aging from a historical and comparative perspective. Presents a minority-feminist perspective on women and aging and discusses modernization and aging in the Anicinabe context. Reviews black perspectives on aging and cultural factors affecting self-assessment of health satisfaction of Asian Canadian elderly. Examines the barriers of age, race, and ethnicity faced by women, along with strategies to change services for the ethnic elderly. Discusses social integration and institutionalization of older adults. Includes chapter references. (MM) (AgeLine Database, copyright 1996 EBSCO Publishing, Inc., all rights reserved)


PURPOSE: Cancer is the leading cause of death among Asian Americans, yet little is known about their use of hospice care. We examined hospice use by Asian patients compared with white patients, and assessed whether utilization differs among those born in the United States or abroad. METHODS: We studied Asian and white Medicare beneficiaries registered in the Surveillance, Epidemiology, and End Results (SEER) Program who died of primary lung, colorectal, prostate, breast, gastric, or liver cancer between 1988 and 1998. We used logistic regression to determine the effects of race/ethnicity and birthplace on hospice use, adjusting for demographic characteristics, managed care insurance, year of diagnosis, tumor stage at diagnosis, and tumor registry. RESULTS: Of the 184,081 patients, 5% (n = 8614) were Asian Americans, of whom 45% (n = 3847) were foreign born. Compared with whites, Asian Americans were more likely to be male, married, and enrolled in managed care. Compared with U.S.-born Asian Americans, foreign-born Asian Americans were more likely to reside in low-income areas. After adjustment, patients who were Asian American (odds ratio [OR] = 0.67; 95% confidence interval [CI]: 0.62 to 0.73) and born abroad (OR = 0.90; 95% CI: 0.86 to 0.94) were less likely to use hospice care than were white patients. These results were consistent across the six cancer diagnoses that were examined. CONCLUSION: Older Asian Americans dying of cancer, especially those who are born abroad, are less likely than white patients to use hospice care at the end of life. Additional research is needed to understand the reasons for these differences and to eliminate potential barriers to hospice care.


This study explored factors associated with alcohol consumption among Asian American older adults by analyzing responses to the California Health Interview Survey: Older Adult Survey of 2003 by 612 Asian Americans, ages 65 to 85. The literature suggests that alcohol use is common among older adults. This study found that most of the sample (68.6%) did not consume alcohol. Only 2.5% reported binge drinking in the prior month. The proportion of males (62.5%) who consumed alcohol was much higher than the proportion of females (37.5%), a finding that was consistent with prior research. Among chronic illnesses, there was a significant relationship between alcohol consumption and diabetes and high blood pressure. There was also a statistically significant relationship between alcohol consumption and social support indicators, such as availability of someone for relaxation, availability of someone to understand problems, and availability of someone to love and make one feel wanted. (Author Abstract, used by permission) (AgeLine Database, copyright 2008 AARP, all rights reserved)
Many Chinese customs are based on the philosophy of Confucianism; this concept includes the value of both strong family bonds and education, and certain beliefs about the treatment of the body. Traditional Chinese medicine is not simply pharmacologic in nature; it encompasses diet, herbal, and folk methods. It relies on harmony between yin and yang, both in the body and in the environment. When encountering an elderly Chinese client, a nurse must assess not only the health history of the client, but also his or her use of concomitant traditional Chinese medicine, his or her role in the family, the structure of the family, and any existing language barriers. Certain ethnic characteristics may be present in Asians that may affect pharmacologic therapy in Chinese elders. These characteristics include a deficiency of the active form of dehydrogenase, fast acetylation in the liver, and smaller reserves of body fat than clients following typical American diets.
scales, from the nation to a focus on the cities of Vancouver and Toronto. Using seniors' data culled from the 1996 Canadian Census PUMF, National Population Health Survey, and General Social Survey Cycle 11, a series of logistic regression models are presented which emphasize the connection between demographic, economic, cultural and health-related factors and the living arrangements of Canadian seniors. The analysis of these data suggests that living arrangements are strongly conditioned by a mix of economic, cultural, demographic and health-related factors. These findings suggest that the heterogeneity of seniors needs to be taken into account in any policies involving the living arrangements of Canadian seniors. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Quantified the impact of achieving specific Healthy People 2010 targets and of eliminating racial and ethnic health disparities on summary measures of health. Age-specific death rates were obtained from U.S. vital statistics for 1998, the original baseline year for the Healthy People 2010 objectives, to calculate life expectancy. Healthy life expectancy (HLE) was calculated using age-specific prevalence rates of activity limitation caused by chronic health conditions. Age-specific rates were then examined for each of the 5 major racial/ethnic groups in the United States. Because the Asian/Pacific Islander (API) population had the lowest activity limitation rates, it was assumed that to meet the targeted objective of eliminating racial and ethnic disparities, the entire U.S. population would have to achieve activity limitation levels equal to those of the API population. Results revealed that attainment of Healthy People 2010 mortality targets would increase life expectancy by 2.8 years, and reduction of population wide mortality rates to current API rates would add 4.1 years. HLE would increase by 5.8 years if Healthy People 2010 mortality and assumed morbidity targets were attained and by 8.1 years if API mortality and activity limitation rates were attained. (AR) (AgeLine Database, copyright 2004 AARP, all rights reserved)


This study investigated housing issues concerning Chinese American elderly, with a focus on the influences of ethnic association and housing types on social support networks and health status. An adequate housing environment that fits one's needs is essential to the well-being of the elderly. Housing is more than a physical unit, it is an environment supporting the personal, social and emotional needs of the individual. While progress has been made in the United States to provide senior housing and service programs to assist older Americans in maintaining their independence and well-being, dominant cultural values generally guide policymakers and professionals in planning and implementing senior programs, without considering the specific needs of ethnic elderly immigrants. The Chinese American population is the largest Asian Pacific American subgroup in the United States, with those aged 65 and above growing at the fastest rate among all older Americans. More than 80% of Chinese elderly are immigrants who face cultural and language barriers, which keep them from accessing existing senior housing programs. This study sought a deeper understanding of the housing characteristics of Chinese American elderly for the purpose of guiding future development of ethnic-appropriate senior housing and related social services. A sample of 260 elderly Chinese Americans was drawn from community senior organizations and aggregated senior housing facilities in both Chinese communities and general communities. Data were collected using semi-structured survey questionnaire including the Lubben Social Network Scale (LSNS-18) and Health Survey (SF-12v2). All demographic and contextual factors were analyzed in relation to four residential settings based on ethnic association and housing types. Findings based on descriptive statistics, analysis of the variance,
and multiple regression analysis, revealed a diverse pattern of housing settlement, which influenced social support networks and physical health status according to the demographic and socioeconomic characteristics of the Chinese elders. Mental health status appeared to be independent of housing arrangements. Educational level, number of children, and age were major personal factors predictive of housing arrangements, social networks and health status. Quantitative findings were complemented by qualitative data, providing an in-depth explanation of the Results. Implications for policy and practice were discussed. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 AARP, all rights reserved)


Examined the health-seeking behavior of older Chinese Americans, focusing on the influences of family network, cultural values, and immigrant experience in their use of health resources. Data were obtained from focus-group interviews with 25 Chinese American immigrants aged 60 and older (mean age 72.05). Survey questionnaires in Chinese were used to compile demographic data. Results suggested a shift from traditional expectations of filial piety to more dependence on neighbors and friends, and a genuine adaptability to combining Eastern and Western health care modalities. Immigration was not proposed by the participants as an explanation of shifts in values or expectations for family support. (MM) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Explored social work policy and practice implications of the experiences of women who have immigrated to the United States. Twenty-five women aged 60-89 who had immigrated to the United States from the Caribbean or Asia 10-50 years before participated in qualitative interviews. Information gleaned from their life stories was applied to 4 areas of policy and practice: initial impressions of the United States and receptions; work, economic issues, and the social safety net; health-related matters; and cultural issues and gender roles. Results suggest that participants' early experiences here would have benefited from accurate and timely information about U.S. culture and customs; opportunities to learn English; and sensitive support around issues of racial prejudice and discrimination. Policy and practice advocacy for aging immigrant women needs to focus on Social Security reform that assures a basic entitlement level that cannot be reduced and the maintenance of safety net programs such as Supplemental Security Income, food stamps, transportation, and subsidized housing. Limitations on health coverage for immigrants represent another urgent area for social work policy advocacy. In addition, older women from other cultures may choose to use alternative health strategies along with modern medicine, and there may be cultural barriers to seeking care for mental health issues, so social workers must consider multiple factors before recommending professional assistance for these women. Helping them maintain their cultural identities and handle the changing roles of women in this country is another complex and very important area of responsibility for social workers. (KM) (AgeLine Database, copyright 2006 AARP, all rights reserved)


The United States faces new challenges in meeting the needs of the Pacific/Asian elderly because of the tremendous influx of immigrants and refugees during the 1970's. In Seattle-King County, Wash., which has a population of 5,800 elderly Pacific/Asians, several service programs exist. The Indochinese Refugee Health Screening Project carries out initial health screening and makes referrals to
neighborhood-based clinics. Many voluntary community agencies provide supports to Pacific/Asian elderly. The Washington State Commission on Asian American Affairs serves as a liaison between the State government and the Pacific/Asian community. The Seattle-King county Division on Aging has received funding from the Administration on Aging to develop a project that will link the majority culture aging network with voluntary service organizations in the Pacific/Asian community. The project will be administered by the Asian Counseling and Referral Service, a multilingual, multicultural, and multiservice agency. Psychological adjustment is the most difficult problem facing elderly refugees and immigrants. Other service needs exist in the areas of housing, employment, health, welfare, transportation, and teaching English as a second language. When elderly refugees and immigrants are unable to learn English, they lose their traditional role as a source of wisdom and become dependent family members. (CI) (AgeLine Database, copyright 1984 AARP, all rights reserved)


This study sought to understand the problem of the low completion rate of living wills and health care proxies among the elderly Chinese Americans living in metropolitan communities. Grounded in the framework of acculturation theory, it examined two contrasting normative patterns, i.e., individualism and Confucianism, representing elderly Chinese Americans' host culture and home culture respectively. The research design was a cross-sectional quantitative inquiry with a qualitative component. Convenience sampling was used to select 200 elders from two senior centers in Flushing, NY, where Asian immigrants are concentrated. Structured interviews were conducted using a 97-item questionnaire. A set of unstructured questions was included to obtain more in-depth qualitative information focused on values toward end-of-life issues. The quantitative data was analyzed using descriptive and inferential statistics. Binary logistic regression was applied to statistically control for intervening and alternative variables. The completion of the documents was related primarily to the elderly Chinese immigrants' values toward end-of-life decisions and to their knowledge about the living will/health care proxy, as well as their access to information and services. In contrast to their cultural norms, respondents were able to discuss what they thought about issues related to death and dying and were willing to adapt to the host country's legal requirements. The study contributes to social work knowledge by providing a better understanding of the completion of living wills and health care proxies among a group of minority elders, by meeting the need for more empirical studies within the social work profession, by providing information relevant to the gerontological component of the social work education curriculum, and by the enhancement of social work practice in helping clients make end-of-life decisions, especially the minority elderly. The study also provides data supporting efforts to amend the Patient Self-Determination Act (PSDA) to make it more politically viable and ethnically sensitive. However, the study was geographically limited and the use of convenience sampling may have resulted in the omission of certain subjects. Caution should therefore be exercised in generalizing the findings. Replication studies utilizing more rigorous research designs are recommended. (Author Abstract, used by permission) (AgeLine Database, copyright 2006 AARP, all rights reserved)


Conducted focus groups in Australia with older adults of different ethnic backgrounds to explore the participants' concerns about medications, their relationships with pharmacists and doctors, and awareness of their health rights as consumers. Findings from 12 focus groups were studied, each group having 7-12 participants aged 60 and older. Four groups were conducted for Anglo, 3 for Italian, 2 for Chinese, 2 for Arabic, and 1 for Greek participants. Common concerns among participants included
inadequate labeling of medications, understanding and remembering the doctor’s verbal instructions, and inadequate warning of possible side effects. Anglo participants differed from participants of other ethnicities in their lack of discussion of herbal remedies, language, relationship with pharmacist and doctor, and awareness of health rights. Findings specific to individual ethnic groups concerned expectations, responses to the cost of medicines, and preference for a doctor of a specific gender.


Elderly Chinese-Americans residing in the community were compared to a sample of elderly community resident Caucasian-Americans on tests that measured psychological and somatic complaints, mood states and ability to perform activities of daily living. Contrary to expectations based on prior results, the Chinese-Americans did not admit to more somatic distress or somatic symptoms than their Caucasian-American counterparts. Rather, they reported less somatic as well psychic distress than the Caucasian-Americans with few exceptions such as greater concern about memory loss. Chinese-Americans showed greater moderation in expression of emotions and feelings than the Caucasian-Americans. Chinese-American women, however, rated themselves as less proficient in the performance of activities of daily living such as use of public transportation, handling of finances and caring for household chores than the Chinese-American men and Caucasian-American men and women.


Presents the recommendations for the 1995 White House Conference on Aging (WHCoA) developed by the National Asian Pacific Center on Aging. Background demographic data on Asian Pacific Island American (APIA) elders are provided based on 1990 Bureau of Census data, showing elders aged 65 and over to consist of 30 percent Chinese, 23 percent Japanese, 23 percent Filipino, 8 percent Korean, 5 percent Asian Indian, 4 percent Vietnamese, 2 percent Hawaiian, and 5 percent other APIA. Recommendations are provided for cross-cutting concerns, such as maintaining eligibility for all services for all legal immigrants; requiring translation of public documents into commonly used languages; requiring reporting of ethnicity and race of clients served in senior services and health clinics; targeting Older Americans Act funds for minority elders in greatest need; supporting community-based services for the elderly; reducing the wait for the language waiver for immigrant elderly to 10 years’ residence; increasing grants to bicultural students for advanced degrees in health sciences, gerontology, and social services; and providing funding for national minority organizations on aging. In addition, recommendations are provided for income security and housing and supportive services. Charts are included on ethnic composition of APIA elders, percentage of foreign-born APIA aged 65 and over in 1990, and poverty rates of APIA aged 65 and over by ethnicity. (TS) (AgeLine Database, copyright 1995 AARP, all rights reserved)


OBJECTIVE: We conducted a cluster randomized clinical trial to compare the benefit of offering on-site mobile mammography in addition to an outreach program designed to increase mammography use by educating patients. SUBJECTS AND METHODS: We recruited a consecutive volunteer sample of 499
women ranging in age from 60 to 84 years who had not undergone mammography in the previous year to participate in a cluster randomized clinical trial about the benefit of on-site mobile mammography. Subjects were recruited from 60 community-based sites where seniors gather. The intervention included a structured on-site multicomponent educational program with or without available on-site mobile mammography. The primary outcome measure was self-reported receipt of mammography within 3 months of the intervention. RESULTS: Women in the group offered access to on-site mammography and health education were significantly more likely than those in the group offered health education only to undergo mammography within 3 months (55% vs 40%, p = 0.001; adjusted [for clustering] odds ratio, 1.83; 95% confidence interval, 1.22-2.74). Gains from offering on-site mammography were shown for several ethnic and sociodemographic subgroups and were especially large for Asian American women. CONCLUSION: Offering on-site mammography at community-based sites where older women gather is an effective method for increasing breast cancer screening rates among older women and may be particularly effective for some subgroups of women who traditionally have had low screening rates


OBJECTIVE: To identify and describe barriers to access to mental health services encountered by ethnoracial seniors. METHOD: A multiracial, multicultural, and multidisciplinary team including a community workgroup worked in partnership with seniors, families, and service providers in urban Toronto Chinese and Tamil communities to develop a broad, stratified sample of participants and to guide the study. This participatory, action-research project used qualitative methodology based on grounded theory to generate areas of inquiry. Each of 17 focus groups applied the same semistructured format and sequence of inquiry. RESULTS: Key barriers to adequate care include inadequate numbers of trained and acceptable mental health workers, especially psychiatrists; limited awareness of mental disorders among all participants: limited understanding and capacity to negotiate the current system because of systemic barriers and lack of information; disturbance of family support structures; decline in individual self-worth; reliance on ethnospecific social agencies that are not designed or funded for formal mental health care; lack of services that combine ethnoracial, geriatric, and psychiatric care; inadequacy and unacceptability of interpreter services; reluctance of seniors and families to acknowledge mental health problems for fear of rejection and stigma; lack of appropriate professional responses; and inappropriate referral patterns. CONCLUSIONS: There is a clear need for more mental health workers from ethnic backgrounds, especially appropriately trained psychiatrists, and for upgrading the mental health service capacity of frontline agencies through training and core funding. Active community education programs are necessary to counter stigma and improve knowledge of mental disorders and available services. Mainstream services require acceptable and appropriate entry points. Mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups, such as providing comprehensive care for seniors


Reviews the literature on the mental health status of Asian elders. After a brief overview of the demographics of this population, three themes are explored: diagnostic problems of foreign-born Asian groups, major barriers to treatment for both foreign-born and American-born Asians, and biological differences, including differing dose requirements and drug reactions. The literature on Asian elderly, which consists primarily of case reports or small samples, refutes the stereotype of this group as a "model minority" characterized by positive aging, good mental health, and family solidarity. Suicide rates among Japanese and Chinese are not any lower than the general elderly population.
Language barriers and a shortage of skilled bilingual staff impede the use of existing mental health questionnaires for clinical screening. Cross-cultural studies often show high rates of depression and schizoid subscales among Asian respondents, which is attributed to the Eastern value placed on stoicism and self-sacrifice. There may not be construct validity for culturally sensitive diagnoses. Elderly parents who join their families in the United States may be at particular risk for psychiatric problems. Asian elderly have low utilization rates for psychiatric services and do not use nursing homes. Recommendations are offered for meeting the needs of Asian elders: professionals should be sensitized to cultural issues, minority research should be expanded, outreach efforts and translation should be provided by community programs, and culturally distinct projects should involve alternate therapies, including appropriate folk cures. (UH) (AgeLine Database, copyright 1992 AARP, all rights reserved)


No Abstract Available


PURPOSE: Even though consumer-directed care models are being advocated for use among elder populations, there are few data on the extent of elder interest in participating in the management of community long-term-care services, who they want involved in making these decisions, or their perceptions regarding the relative importance of different service choices. In addition, little is known about how elder preferences for consumer direction may vary by race/ethnicity. DESIGN AND METHODS: With use of a cross-sectional research design, a sample of 731 elders including 200 African American, 200 Chinese, 131 Latino, and 200 White Western European American elders was investigated. New measures were created to assess level of control desired by elders in different areas of community long-term-care service delivery and preference for consumer direction. RESULTS: Multivariate analyses found significant differences between and within race/ethnic groups for preferences for levels of consumer-directed care. IMPLICATIONS: Study findings suggest that consumer direction occurs along a continuum, with elders desiring control over some service areas but not others, and the importance of recognizing heterogeneity within racial/ethnic groups regarding consumer-directed care


The prevalence of Alzheimer's disease and multi-infarct dementia was determined in a Chinese-American nursing home population. Sixty-one Chinese-American residents (mean age 81.6) of a nursing home in an urban community were studied by means of chart reviews, personal interviews, neurological examinations, and a modified Mini-Mental State test. Demented patients were scored on the Modified Hachinski Ischemia Scale. Of the 61 residents examined, 58 were demented when DSM-III criteria were used. Of those 58 demented residents 44 had multi-infarct dementia and 4 had dementia due to other identifiable causes. The remaining 10 had dementia of an unknown etiology, with 7 of those meeting diagnostic criteria for possible Alzheimer's disease. The ratio of multi-infarct dementia to Alzheimer's disease in this population was 4.4-6.3 to 1, in contrast to the low relative prevalence of multi-infarct dementia in most American nursing home populations. It is suggested that true ethnic differences may exist in the prevalence of Alzheimer's disease and in the relative prevalences of multi-
infarct dementia and Alzheimer’s disease. (LS) (AgeLine Database, copyright 1987 AARP, all rights reserved)


Summary: The emerging evidence of ethnic variations in apolipoprotein polymorphism and Alzheimer disease risk shows that one cannot generalize findings based on a single cultural group too broadly (Tang et al., 2001). Presence of one apolipoprotein E epsilon 4 allele is a stronger risk factor for Alzheimer disease in whites and Asians than in blacks (Farrer et al., 1997). Environmental or genetic cofactors may modulate the effects of epsilon 4 on beta-amyloid metabolism differently in different subpopulations (Shadlen, 1998). Recognizing this, the Alzheimer’s Association has extended its goals to strengthen the scientific information base on the interactions of population diversity and Alzheimer disease heterogeneity (NIA, 1998). This new focus is timely since minority elderly are the most rapidly increasing segment of the elderly population (Lilienfeld and Perl, 1994, Brookmeyer et al., 1998). In this article, the authors highlight recent progress in research on Alzheimer disease among culturally diverse populations with a special emphasis on gaps in the knowledge base. The authors recommend four priorities for future Alzheimer disease research: (1) determine whether genetic causative factors interact differently in different populations; (2) reexamine the nature and role of cerebral ischemia and infarction and variations in symptom severity of Alzheimer disease; (3) explore the interaction of genes and environmental influences that are protective against Alzheimer disease; and (4) recruit and enroll ethnically diverse subjects in Alzheimer disease clinical trials.


Examined translation difficulties encountered during interviews with mentally ill older adults from non-English-speaking backgrounds. Older adult patients from Eastern European and Asian backgrounds were assessed by a psychogeriatric service in Melbourne, Australia, using interpreters with varying degrees of expertise: professional interpreters with training in mental health, professional interpreters without training in mental health, clinical staff, nonclinical staff, and relatives and friends of patients. It was found that difficulties in translation occurred at three levels: complex interactions between interviewer, interpreter, and patient; the mode of translation (in person or by telephone); and the nature of the mental illness. It was found that professional translators with training in mental health worked best, and that each of the other types of translators had both positive and negative effects on the interview process. Interpretation by relatives and friends was biased because they sometimes did not understand the interviewer’s question or the patient’s answer, had poor knowledge of technical terms, had misguided good intentions, and occasionally had unscrupulous intentions. Psychiatric issues were best represented and patients felt more reassured when staff members translated. However, some staff asked leading questions, were biased toward information relevant to their discipline, and misinterpreted in complex areas when translating for other disciplines. (MM) (AgeLine Database, copyright 1999 AARP, all rights reserved)

178. Spitzer, D., Neufeld, A., Harrison, M., Hughes, K., & Stewart, M. (2003). Caregiving in transnational context: ”my wings have been cut; where can I fly?”. *Gender and Society*, 17(2), 267-286.

Explored the experiences of Chinese and South Asian immigrant women in Canada who were caring for family members with chronic health problems. Semistructured interviews were conducted with 18 Chinese (aged 29-71) and 11 South Asian (aged 40-75) female caregivers. In addition, 6 women
provided a second interview and allowed researchers to observe them in the process of their routine of caregiving. Four focus group sessions, 2 with caregivers and 2 with health professionals and policymakers, were held to allow participants to discuss the program and policy relevance of the findings. Data were subject to theme and content analysis. Responses were surprisingly similar despite differences in culture and length of residency in Canada. The women were regarded as natural and appropriate family caregivers who experienced significant strain juggling the competing demands of work and multiple generations of family in a new environment. Despite these pressures, the women rejected the notion of a caregiving burden, focusing instead on the rewarding aspects of caregiving obtained through cultural role fulfillment. In the interest of maintaining cultural values and identity, women did not want, nor were they able, to renegotiate their caregiving roles. These caregiving arrangements were more costly to the women in Canada than in their countries of origin. (AR)

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Background: Depression is a common mental health problem among Chinese elderly, but it often goes undiagnosed and untreated. Despite an increase in the population of elderly Chinese immigrants in the US, there have been few published studies on this topic. Objective: Our purpose was to determine the extent of depression in the participant population, using an updated Chinese translation of the original 30-item Geriatric Depression Scale (GDS; Yesavage et al., 1983). Study Design: A convenience sample of 102 Mandarin speaking Chinese elderly participants in two senior centers in Santa Clara County, CA was recruited. Results: A total of 29.4% of participants showed symptoms of depression, higher than the range found in the older adult American population (13-20%). Those most likely to be depressed ranged in age from 60 to 69 years (32%), lived with their children (37%), rated their financial and health status as below average, had less than a high school education, and lived in the US for less than five years. Conclusion: This updated Chinese translation of the GDS is a promising screening measure to detect depressive symptoms in elderly Chinese.


Depression is common in the elderly, and is also the major reason for suicidal behavior in this age group. Since worldwide migration has increased over the last few decades, the close relationship between immigrants and mental illness has attracted much attention. Health programs and strategies have been established to ensure that individuals in minority groups have access to appropriate health care services, and research into depression in immigrants has become very important.


BACKGROUND: Little is known about the time health professionals spend with inpatients that are close to the end of life. SUBJECTS AND METHODS: We asked day-shift nurses to use a standardized log sheet to record how much time they spent in various categories of activity for 146 seriously ill medical inpatients with poor prognoses at 2 teaching hospitals. RESULTS: The mean patient age was 68, and the mean APACHE-III physiology score 28; 59% were white, 56% were women, 41% had cancer or HIV, and 81% had do not resuscitate (DNR) orders. The mean amount of time nurses spent with patients per 12-hour day shift was 53 min. In bivariate analyses, sex, religion, diagnosis and insurance status were not associated with nursing bedside time. In an ANOVA model, patients with DNR orders received
more time than those without DNR orders (56 vs. 39 min, P = 0.04), and white patients received more bedside time than nonwhites (57 vs. 46 min, P = 0.01), even after controlling for severity of illness and DNR status. Among the 47 mentally alert patients who could be interviewed, symptom severity, quality of care, and satisfaction ratings were not associated with nursing bedside time. CONCLUSIONS: In this population, nurses spent less time with nonwhite patients and more time with patients with DNR orders. That patients with DNR orders received more time may be reassuring. However, further investigation will be required to confirm these results, to understand why nonwhite patients appear to have received less bedside nursing time, and to investigate further the relationship between time, satisfaction, and quality of care.


Provides a description and evaluation of a project designed to increase public awareness in Hawaii of Alzheimer’s disease (AD) and the supportive resources available to individuals with AD and their caregivers. The Helping Families Understand Alzheimer’s Disease Project developed and implemented a multilingual, multimedia campaign on information and support services available to individuals with AD and their families, focusing on Asian and Pacific Islander Americans (APIAs). A cultural research team was organized and sought input from the APIA community through focus groups and key informant interviews. Seven videos with accompanying informational materials in APIA languages were produced, assembled as an information kit, and were disseminated throughout the United States via state aging and Alzheimer’s organizations. Evaluation of the project points to significant changes in perceptions of AD and in attitudes toward service utilization among APIAs who have viewed the videos, along with the value of the multilingual materials from the perspective of professional service providers and indigenous community leaders. An appendix provides materials developed by the project and comments by outside evaluators on the video transcripts. (MM) (AgeLine Database, copyright 1997 AARP, all rights reserved)


Based on a qualitative study of home care workers, this paper aims to understand elder abuse of Chinese Canadians. The findings show disrespect is the key form elder abuse takes in the Chinese community. As a culturally specific form of abuse, disrespect remains invisible under categories of elder abuse derived from a Western cultural perspective. Applying a social exclusion framework to understand the dynamic of elder abuse, we argue that as a marginalized racial minority immigrant, an elderly Chinese person's vulnerability to abuse is increased under conditions of social isolation.


Examined cultural barriers to mammography, clinical breast examination, and breast self-examination among older Chinese American women. One hundred Chinese American women aged 60-102 (mean age 71.81) recruited from senior centers completed a questionnaire that included measures of demographic characteristics, health history, health insurance coverage, breast cancer screening, common and cultural barriers to screening, and acculturation. Logistic regression models found insurance coverage for mammography and acculturation to be significant predictors of having had a mammogram at least once. Low perceived need/lack of physician recommendation and recency of
physical examination were significant predictors of having had a mammogram in the past year. Acculturation and modesty were significant predictors of having had a clinical breast examination at least once, while recency of physical examination was a significant predictor of having had a clinical breast examination in the past year. Reliance on medical professionals for screening and forgetting were significant predictors of having performed breast self-examination at least once, and forgetting was a significant predictor of regular performance of breast self-examination. The results suggest that both common and cultural barriers play a role in breast cancer screening among older Chinese American women. (MM) (AgeLine Database, copyright 2002 AARP, all rights reserved)


Reviews the literature on the social, health, and economic status and service needs of Asian and Pacific Islander (API) elders. API elders constitute the fastest-growing racial group aged 65 and older in the U.S. and include 26 ethnic subgroups--among them Chinese, Japanese, Filipino, Vietnamese, Korean, and Laotian. Aggregate data have been used to characterize APIs as the "model minority" and present a picture of uniform health, education, and social advantage. Disaggregated data (broken down by ethnic subgroup), however, reveal the bimodal nature of the health and social status of different API groups, with the success of some subgroups masking the severe problems of other segments. Many immigrant API elders have substantially fewer economic and social resources than their white and other minority counterparts. Disparities also exist among subgroups in health status and activity limitations. Further research is needed that considers the multiple complexities of the heterogeneous API population. Implications for public policy and service provision are discussed. (PH) (AgeLine Database, copyright 1995 AARP, all rights reserved)


INTRODUCTION: Research in cancer care satisfaction itself is scarce; investigation of the role of ethnicity in care satisfaction is even rarer. OBJECTIVE: The present study examined relationships between ethnicity and satisfaction with care in a sample of 759 patients diagnosed with three different types of cancer (lung, head and neck, or gynecologic) from a large tertiary cancer hospital. METHOD: Respondents filled out an assessment package that consisted of demographics, the Ware Patient Satisfaction Questionnaire-III (PSQ-III), 17 additional items constructed by the research team to examine other specific areas of satisfaction, and the Psychological Screen for Cancer (PSSCAN) Part C, to measure anxiety and depression. RESULTS: In a multivariate analysis, being non-White emerged as the primary predictor variable (beyond patient age, gender, marital status, education, cancer site, duration of illness, and presence or absence of metastases) of several of the PSQ-III satisfaction subscales. Conclusion. Health care systems must consider how to become more responsive to the needs of all individuals, regardless of their ethnic background and levels of acculturation.


Explored health, psychosocial, and cultural determinants of the use of traditional Chinese medicines (TCM) and Western medicines among Chinese Canadian older adults. One hundred six Chinese older adults living in Canada completed face-to-face interviews that included a Chinese version of the Minimum Data Set for Home Care and supplementary questionnaires. All medications including TCM, prescription, and over-the-counter medications were reviewed and recorded. Multivariate regression models found that those experiencing pain symptoms were almost 10 times more likely to use TCM
than those without pain. The odds of using TCM for those that were hospitalized were 15 times greater than for those not hospitalized. A curvilinear association between use of TCM and health beliefs was found. Living with a child, physical health problems, and number of diseases were associated with Western medicine use. Both experiencing pain symptoms and previous hospitalization increased the odds of combined use of TCM and Western medicine. Living with a child was significantly associated with a reduced likelihood of combining TCM and Western medicines. Results suggest that targeting pain and social isolation, as well as an education program focusing on the importance of preventive health, will be important in helping Chinese Canadian older adults. (AR) (AgeLine Database, copyright 2002 AARP, all rights reserved)


Compared the health perceptions, concerns, and coping strategies among older adults in two geographically distant Asian and Pacific Islander American communities. Sixty-three Chinese persons in Texas and Pennsylvania aged 55 and older completed personal interviews conducted in an open-ended question format, while in-depth interviews with 58 Chamorros aged 55 and older in Guam followed a modified life history format. Both interviews allowed informants to describe their perceptions of health and illness, health care concerns, and coping strategies. The grounded theory method was used to compare focused ethnographies and to generate a cross-cultural analysis. The health perceptions of these two communities were manifest in two themes: a sense of holism among body, mind, and spirit and an orientation toward others. The health concerns of these two communities included universal experiences of aging, structural elements within the American health care system, and cultural changes impacting health. A significant coping strategy used was adaptation to changes while maintaining continuity. An important difference between the Chamorros and the Chinese had to do with the perspective of the older adults. The Chamorro elders believed strongly in remaining functionally active and involved in their family system and community, while the Chinese tended to focus on a more contemplative rather than functional component. Based on the significance of culture in defining health and health behaviors in these two populations, it is suggested that health professionals provide health care in a culturally aware and competent manner. (AR) (AgeLine Database, copyright 2002 AARP, all rights reserved)


Investigated quality of life among Chinese older adults living in Melbourne, Australia. A total of 60 people aged 65 or older were recruited: 30 residents from 3 Chinese hostels (mean age 82.4) and 30 members of a Chinese welfare society (mean age 75.0). The participants completed measures of health status, functioning, self-reported life satisfaction, level of depressive mood, and independence. In-depth interviews were conducted with a convenience subsample of 6 informants to explore other important aspects of their quality of life. The hostel group was found to be less healthy, less independent, more depressed, and less satisfied with their lives than were the community group, but nonetheless were generally satisfied with their lives. Good quality of life was found to be associated with good health, independence, secure finance, a meaningful role, strong ethnic community and family support, low expectations, no worries, and a sense of familial love and respect. The findings reinforce the notion that quality of life is truly multidimensional and demonstrate that high self-rated quality of life in old age is achievable. (AS) (AgeLine Database, copyright 2004 AARP, all rights reserved)

This article uses survey data to investigate health effects of racialization in Canada. The operative sample was comprised of 91,123 Canadians aged 25 and older who completed the 2003 Canadian Community Health Survey. A “racial and cultural background” survey question contributed a variable that differentiated respondents who identified with Aboriginal, Black, Chinese, Filipino, Latin American, South Asian, White, or jointly Aboriginal and White racial/cultural backgrounds. Indicators of diabetes, hypertension and self-rated health were used to assess health. The healthy immigrant effect suppressed some disparity in risk for diabetes by racial/cultural identification. In logistic regression models also containing gender, age, and immigrant status, no racial/cultural identifications corresponded with significantly better health outcomes than those reported by survey respondents identifying as White. Subsequent models indicated that residential locale did little to explain the associations between racial/cultural background and health and that socioeconomic status was only implicated in relatively poor health outcomes for respondents identifying as Aboriginal or Aboriginal/White. Sizable and statistically significant relative risks for poor health for respondents identifying as Aboriginal, Aboriginal/White, Black, Chinese, or South Asian remained unexplained by the models, suggesting that other explanations for health disparities by racialized identity in Canada - perhaps pertaining to experiences with institutional racism and/or the wear and tear of experiences of racism and discrimination in everyday life - also deserve empirical investigation in this context.


*No Abstract Available*


There are two objectives of this project: to undertake a small-scale empirical study and compare the QOL of Chinese seniors in four Chinese Settlement Areas (CSA) in the Toronto CMA, and to critically evaluate four techniques that can be used to measure QOL, including the method developed by Brown et al. (1998), Simple Additive Weighting method (SAW), Decision Matrix Method (DMM), and DECisions on a FINITE set of alternatives (DEFINITE). In this project, a non-random sample of 80 Chinese individuals over 65 were asked to rate their importance and satisfaction level for 14 selected indicators related to QOL. The QOL scores of individuals were calculated and compared using the Brown et al. (1998) method, SAW method and DMM. The four CSAs were classified using their average QOL scores derived from the Brown et al. (1998) method and DEFINITE. This pilot project is a study of the QOL of Chinese seniors living in Toronto. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)


Reviews specific and general issues relevant to recruiting to and providing mental health services for older Asian and Latino immigrants. Discusses special considerations for working with trauma, loss, and dementia in these populations. Presents general issues that apply regardless of presenting problem or treatment foci: assessment (language proficiency, financial strain, and dementia), cultural factors that influence conceptualizations of health and symptom presentation, beliefs about mental illness and
Severe Acute Respiratory Syndrome (SARS) is considered the first virulent infectious disease of the 21st Century by medical professionals worldwide. Aided by international travel, SARS quickly spread to 32 countries in five continents within weeks of its outbreak in Southern China. There are still no definitive treatments for the disease at this time and the mortality rate of 50% for elderly over 65 years of age is a major concern for many elderly. Prevention is deemed the best strategy against SARS to date. It is of great importance to gain an understanding of the use of protective and preventive strategies among Chinese elderly living in Edmonton, as the Chinese are quickly becoming the largest visible minority of Canada. In this study, grounded theory was used to gain an understanding into the process of initiating preventive and protective strategies against SARS among Chinese elderly living in Edmonton. To fully address the cultural component of the study, specific ethnographic strategies were used. Retrospective individual interviews were conducted in Cantonese with 19 Chinese elderly who either lived by themselves, with family members or in a nursing home for Chinese elderly. Data analysis occurred concurrently with data collection. The researcher identified the core category of "Protecting self, family and others" using the constant comparison method of data analysis, and derived a theory consisting of 5 stages. (1) recognizing the threat of SARS, (2) becoming terrified, (3) initiating strategies against SARS, (4) resorting to higher power for comfort and extra protection, and (5) maintaining vigilance against SARS. The findings from this study suggest that while Chinese elderly were seized by the fear of SARS, they were knowledgeable about the different protective strategies against SARS. They initiated these strategies as a responsibility to their family and others in the community. These responsibilities were profoundly influenced by the concept of filial piety, which remains a salient factor in guiding the actions of Chinese elderly in Edmonton. Implications of this study include how health care professionals, especially those who work in the public health sector, could provide support and care for the elderly group in case of a re-emergence of SARS or other similar infectious diseases. (Author Abstract, used by permission) (AgeLine Database, copyright 2006 AARP, all rights reserved)
Multivariate results suggest that Koreans have more depression than Chinese. Those who lived with their spouse and adult children had lower overall psychological well-being and lower positive affect compared to those who lived alone. Having more emotional/companionship support significantly contributed to better overall psychological well-being, having less depression and higher positive affect. Conclusions. A new multidimensional social support measure for use with older Chinese and Koreans could be useful upon further validation. These results suggest that older Chinese and Koreans' psychological well-being may be negatively affected when they live with their adult children. More depression in Koreans may be related to difficulties in expanding their social network beyond Korean-speaking people.


*No Abstract Available*


Explored the relationships between chronic illnesses and depression among older Chinese immigrants. The sample of 177 Chinese-speaking immigrants aged 60-90 (mean age 71.8) was collected in the Greater Boston, Massachusetts, area at various social service agencies and social and religious institutions. The majority (62%) of participants were women, 53% reported being married or living with a partner, and the average length of stay in the United States was 18.4 years. Seven items (4 measuring somatic symptoms and 3 measuring depressed affect symptoms) of a translated version of the Center for Epidemiologic Studies Depression Scale (CES-D) were used to measure depressive symptoms. Independent variables were physical health (self-rated health and number of chronic illnesses), demographics, social support, and health behavior. Arthritis was the most commonly reported chronic illness (43%) that limited respondents' activities; other commonly reported chronic illnesses were back/neck problems (32%), eye/vision problems (29%), hypertension (25%), and walking problems (21%). On average, respondents reported having at least 2 chronic illnesses that limit their activities. Although women reported higher depression scores than men, the differences were not significant. In addition, gender was not a predictor for depressive symptoms in the multivariate models. The findings suggest that arthritis and back/neck problems have a significant association with depressive symptoms among older Chinese immigrants and that medical, psychological, and social work treatment or interventions for depression should take into consideration the impact of chronic illnesses. (SW) (AgeLine Database, copyright 2004 AARP, all rights reserved)

199. Wu, C. J. (2000). *Cyclical migration among elderly immigrants: case of Taiwanese Canadians in Greater Vancouver (British Columbia)*. UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

This thesis empirically examined cyclical migration among elderly immigrants—a phenomenon not addressed previously in the gerontological literature. 169 seniors who immigrated directly from Taiwan comprised the study sample (88 non-migrants and 81 cyclical migrants). They were interviewed to examine: (1) the pattern of, and reason for cyclical migration; (2) determinants of cyclical migration; and (3) the correlates of cyclical migration with health care utilization, social integration and socio-psychological well-being. A synthesis of Wiseman's behavioural model of elderly migration and Northcott's social demographic model of elderly mobility provided the theoretical basis for the research questions. The seasonal migration literature and cultural factors pertinent to the Taiwanese
were also incorporated in formulating the research questions. Based on the findings, it is suggested that for elderly Taiwanese, cyclical migration acts as a way of fulfilling their socio-psychological, health care and economic needs after immigrating to Canada. It is recommended that emphasis be placed on culturally sensitive and accessible health care and social services for immigrant seniors, not necessarily to replace but not to supplement their personal resources. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)


This qualitative study describes how Chinese elders in an American nursing home perceived their food and mealtime experiences. Data collection included 20 meal observations and interviews with 7 residents, 9 family members, and 17 staff members. Field notes and interviews were coded and analyzed using an iterative approach similar to grounded theory. All participant groups described institutional food and meals as individualized, nutritious therapy for medical illnesses. Mealtimes lacked sociability and sharing, and although family members provided Chinese food, they did not eat with residents. Residents generally did not consider the institution's effort to provide an "Asian diet" of hot tea and juk (rice porridge) to be Chinese food. These findings suggest that, for these Chinese elders, the biomedicalized, individualized food service and mealtime caregiving practices stripped food of its meaning as a social, shared mealtime experience with family. Nursing professionals and researchers should understand that provision of culturally competent mealtime care for ethnic (Chinese) long-term care residents involves important food service practices in addition to kinds of food.


Raises issues essential to the nutritional management of an elderly ethnic population in an adult day health center setting. Draws on experiences with the frail Chinese elderly at On Lok Senior Health Services in San Francisco, California. Identifies three factors that affect the population's food consumption patterns: psychosocial dynamics, cultural influences, and physiological and physical limitations. Explains the strategies used at On Lok to address dietary problems, including individual counseling and participation in a congregate meal facility to enhance psychosocial dynamics; inclusion of an awareness of the importance of culture in meal planning and diet counseling; use of home-delivered meals and home health aides to compensate for sensory losses and physical limitations; and encouragement and support from family members and members of the multidisciplinary health center team to foster dietary compliance. (LS) (AgeLine Database, copyright 1986 AARP, all rights reserved)


*No Abstract Available*


Examined the effectiveness of depression screening and the Engagement Interview Protocol (EIP) in identifying and engaging in treatment Chinese Americans with depression in a primary care setting. Chinese American patients who attended a primary care clinic between September 2004 and
September 2005 were screened for depression using the Chinese Bilingual version of the Patient Health Questionnaire (CB-PHQ-9). Patients who screened positive were evaluated using the EIP to establish psychiatric diagnosis and to engage patients in treatment. A total of 3,812 patients (mean age 50) completed the CB-PHQ-9, of whom 113 (3.2%) screened positive for major depressive disorder (MDD). Among those screening positive, 6 had been receiving psychiatric treatment for depression, 57 declined to receive a psychiatric interview or were unable to be contacted, and 50 agreed to be interviewed with the EIP. Of the 50 patients interviewed, 44 (88%) had their MDD diagnosis confirmed; among them, 41 (93%) agreed to receive treatment for depression and 3 (7%) declined intervention. It is concluded that underrecognition and undertreatment of Chinese Americans with depression in primary care settings continue to be prevalent. Recognition of depression can be enhanced by using the CB-PHQ-9, and enhanced cultural sensitivity with the use of the EIP in psychiatric assessment may contribute to success in engaging Chinese Americans with depression in treatment. (KM) (AgeLine Database, copyright 2006 AARP, all rights reserved)


Reviews the activities in which the National Asian Pacific Center on Aging is engaged and presents the results of a study on improving access to health and human services for Asian/Pacific Islander older adults in the United States. A key informant survey approach was used to identify service barriers or problems that older Asian/Pacific Islander Americans faced in receiving culturally responsive services. It was found that all 13 respondents identified differences in language and culture as the primary barriers to accessing health and human services. Slightly over half of the respondents indicated that the client's distrust of government or lack of effective outreach were primary barriers, while nearly half of the respondents identified the lack of government program funding and information as a principal barrier to service access. Appendices provide a copy of the full access to services report, the final report of the International District Asian Pacific Elderly Outreach Project, and recommendations in regard to the provision of long term care to older immigrants. References are included. (MM) (AgeLine Database, copyright 1997 AARP, all rights reserved)


The mortality and morbidity patterns of elderly Chinese-Americans were compared with those of whites. The analysis is based on 1980 data from the National Center for Health Statistics and from the Surveillance, Epidemiology, and End Results cancer registry program of the National Cancer Institute. The educational attainment and occupational patterns of both groups are compared, and data are presented on general mortality, age-specific mortality, and the comparative rates of death from different causes. The average age-adjusted death rate per 1,000 population was 3.5 for Chinese-Americans, in contrast to 5.6 for whites. The age-specific death rates for all causes of death also were lower for Chinese than for the white population. The death rate was higher for males than for females within each group, but place of birth (United States or abroad) had a greater effect than gender on death rates of Chinese-Americans. The four leading causes of death were the same for Chinese-Americans and whites: heart disease, cancer, cerebrovascular disease, and accidents. Compared to whites, however, Chinese-Americans had a lower proportion deaths from heart disease and a higher proportion of deaths from cancer. Chinese-Americans had higher incidence rates for liver and nasopharyngeal cancers and a slightly higher rate of stomach and rectal cancers at advanced ages. Suicide rates were higher for older Chinese-American women than for whites, but there was no difference for men. (CM) (AgeLine Database, copyright 1987 AARP, all rights reserved)

Examined the experiences of Chinese American caregivers who provide care for family members with Alzheimer’s disease (AD). Semistructured, open-ended interviews were conducted with 4 family caregivers aged 36-62 providing care to 4 family members with AD aged 80-90. Respondents were asked about their initial awareness of AD; access to, barriers to, and opinions about AD and dementia care services; views and perceptions on AD; and personal reflections of caregiving experiences. Analysis of the interview data revealed ethnocultural and structural barriers that Chinese American family caregivers experience, including stigmatization of AD in the Chinese community, a lack of knowledge about AD, a lack of culturally and linguistically appropriate AD services, negative interactions with health care providers, and difficulty with English. It is suggested that health care providers, families, and the community need to work together toward better understanding AD and the cultural contexts of AD. (SW) (AgeLine Database, copyright 2004 AARP, all rights reserved)


Examined factors associated with medication practices among community-dwelling Chinese American older adults. One hundred sixty-five Chinese Americans aged 60-91 in the Boston, Massachusetts, area completed a mail survey containing the Medication Practice Questionnaire, Health Status Survey (SF-36), and a demographic questionnaire. Results indicated that language difficulties, cultural barriers in the health care system, lack of health insurance, and not consulting health providers about medication use contributed to poor medication practices among these respondents. Medication practices of Chinese American older adults may be influenced by their meanings of symptoms, the degree of congruence between their culture and that of health care providers, their ability to pay for prescriptions, the degree of difficulty in communication with health care providers, and their knowledge about prescriptions and traditional medicine. It is concluded that to improve medication practices among older Chinese Americans, health care providers must help overcome barriers to care. (KM) (AgeLine Database, copyright 2004 AARP, all rights reserved)


The purpose of this study was to investigate health-promoting measures used by ethnic elderly women. Within the context of this goal, two major research questions were asked: (a) What measures were used by the ethnic elderly women to promote their health? (b) What were the facilitators and barriers with respect to health promotion in this sample? A convenient and purposive sample consisted of 30 elderly women from three ethnic backgrounds—African American, Chinese American, and European American—who reside in an urban area of the northeastern part of the United States. Data were collected through in-depth interviews and survey questionnaires. Content and statistical analyses were employed. Participants identified measures, facilitators, and barriers in relation to promoting their health. These findings provide insight for community health nursing practice.


The purpose of this qualitative study was to explore arthritis management strategies among Chinese immigrants in Calgary, Canada, and to assess factors, that impact on these strategies. Purposive sampling was used to select 19 Chinese immigrants living with arthritis. Data were collected by means
of in-depth interviews. The interview data were analyzed according to the following steps: (1) transcribing interview materials, (2) developing codes, categories and themes, (3) theoretical coding, and (4) laying out the theoretical framework. The results of this study describe factors that impacted on illness management strategies. These include arthritic symptoms, beliefs about arthritis, beliefs about Western medicine based on treatment experience, beliefs about Chinese medicine, perceived barriers to using Chinese or Western medicine and social support. The emerging process of illness management shows that immigrants usually started using self-care remedies, followed by consulting Western physicians, consulting Chinese healers, and then returning to Western medicine. The results illustrate that disease management strategies among Chinese immigrants are impacted by disease, personal and cultural factors. These factors suggest helpful directions to providing culturally sensitive care, which can lead to greater satisfaction and well-being for Chinese immigrants with arthritis.
### Glossary

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Application</th>
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<tbody>
<tr>
<td>Acute</td>
<td>A health (or health related) condition that is acute in nature</td>
<td>This code is applied to abstracts/sources that speak to acute health episodes/illnesses (e.g. heart attack)</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>Intervention for a health condition (or health related condition) using advanced directives</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of advanced directives and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Intervention services directly related to or labeled as 'advocacy'</td>
<td>Used for sources/abstracts that explicitly mention dedicated 'advocacy' services</td>
</tr>
<tr>
<td>Alcohol Consumption</td>
<td>A health (or health related) condition related to alcohol consumption</td>
<td>This code is applied to abstracts/sources that discuss alcohol consumption and/or health issues/problems associated with alcohol consumption</td>
</tr>
<tr>
<td>Alcohol/substance abuse treatment</td>
<td>The intervention(s) mentioned include treatments for alcohol and/or substance abuse</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for alcohol and/or substance abuse</td>
</tr>
<tr>
<td>Aphasia</td>
<td>The health condition discussed/mentioned is aphasia</td>
<td>This code is applied to abstracts/sources that discuss aphasia and/or the challenges associated with it to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Arthritis</td>
<td>The health condition discussed/mentioned is arthritis</td>
<td>This code is applied to abstracts/sources that discuss arthritis and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Asthma</td>
<td>The health condition discussed/mentioned is asthma</td>
<td>This code is applied to abstracts/sources that discuss asthma and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
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<td>Code</td>
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<tr>
<td>Cancer</td>
<td>The health condition discussed/mentioned is cancer (all types)</td>
<td>This code is applied to abstracts/sources that discuss cancer and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>The health condition discussed/mentioned is cardiovascular disease or related to cardiovascular disease/illness (e.g. hypertension, stroke, heart disease)</td>
<td>This code is applied to abstracts/sources that discuss cardiovascular disease and it's variants and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>The health condition discussed/mentioned is hypertension (blood pressure) and is a sub-category of cardiovascular disease</td>
<td>This code is applied to abstracts/sources that discuss hypertension and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Hypertension</td>
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<tr>
<td>Caregivers</td>
<td>Intervention for a health or health related condition as being provided by caregivers</td>
<td>This category describes both informal and, to a lesser extent, formal caregivers of ethnocultural seniors. Caregivers’ issues/challenges related to care provision, such as caregiver burden, for an older adult were considered as grounds for inclusion as these issues indirectly impact the availability/quality of care received by the older adult. Often there were references to family care providers and the interactions of cultural beliefs about family caregiving duties/filial piety.</td>
</tr>
<tr>
<td>Chronic Disease</td>
<td>The health condition discussed/mentioned is chronic disease&quot; or &quot;chronic illness&quot; (all types)</td>
<td>This code is applied to abstracts/sources that discuss chronic disease/illness and the challenges associated with it (and/or it's treatment) to the health and well being of an individual or a group/population. The use of the specific term &quot;chronic disease&quot; constituted the application of the code whereas other diseases considered chronic disease (i.e. diabetes) were labeled according to their individual condition names.</td>
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<tr>
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<tr>
<td>Communication</td>
<td>The interventions mentioned focus on/include communication as component to the process of treatment/care</td>
<td>This code is applied to sources/abstracts that mention/discuss communication in any form (i.e. written or verbal) between providers of care and recipients and the possible impact of communication on the success/effectiveness of specific and/or non-specific interventions/treatments.</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>Intervention - Cultural Competence</td>
<td>Refers to abstracts/sources that mention/recommend 'cultural competence' explicitly and/or types of care that are culturally sensitive or culturally 'aware'</td>
</tr>
<tr>
<td>Day Programs</td>
<td>The intervention(s) mentioned include adult day programs</td>
<td>This code is applied to sources/abstracts that mention/discuss the use of, availability and types of services included in adult day programs. The terms 'day centre' or 'day programs' were included in this category.</td>
</tr>
<tr>
<td>Dementia</td>
<td>The health condition discussed/mentioned is Dementia or cognitive impairment</td>
<td>This code is applied to sources/abstracts that mention or focus on Dementia generally and/or other types of dementias (non-Alzheimer’s).</td>
</tr>
<tr>
<td>Dementia - Alzheimer’s</td>
<td>The health condition discussed/mentioned is Alzheimer's Disease</td>
<td>This code is applied to sources/abstracts that mention or focus on Alzheimer’s disease specifically and is referred to specifically by the author. Although it is recognized as a type of dementia, it was coded distinctly from dementia for tracking purposes.</td>
</tr>
<tr>
<td>Dentist</td>
<td>The intervention(s) mentioned the use of/treatments by a dentist</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for oral health issues by a dentist</td>
</tr>
<tr>
<td>Diabetes</td>
<td>The health condition discussed/mentioned is diabetes</td>
<td>This code is applied to abstracts/sources that discuss diabetes and/or the challenges associated with it (and/or it's treatment) to the health and well being of an individual or a group/population.</td>
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<tr>
<td>End of Life</td>
<td>The health issue discussed/mentioned is end of life</td>
<td>This code is applied to abstracts/sources that discuss end of life and the challenges associated with it (and/or available care options) to the well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Ethics</td>
<td>The intervention(s) mentioned the issue of ethics in providing treatment/care</td>
<td>This code is applied to sources/abstracts that mention/discuss the role of ethics (such as bioethics) in the care/treatment process.</td>
</tr>
<tr>
<td>Euthanasia</td>
<td>The intervention mentioned was assisted(or passive) suicide/euthanasia</td>
<td>This code is applied to sources/abstracts that mention/discuss euthanasia and/or assisted and/or passive suicide as an intervention option for the end of life.</td>
</tr>
<tr>
<td>Exercise</td>
<td>The intervention(s) mentioned include using exercise</td>
<td>This code is applied to sources/abstracts that mention/discuss exercise (or physical activity) as a treatment/intervention for a variety of conditions or as a preventative/health promotion measure</td>
</tr>
<tr>
<td>Frailty</td>
<td>The health condition discussed/mentioned is frailty</td>
<td>This code is applied to abstracts/sources that discuss frailty (or frail elderly) and/or the challenges associated with it (and/or it's treatment/management) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Health Behaviour</td>
<td>The abstract mentions or discusses health behaviour (e.g. help seeking behaviour or behaviours related to health).</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for a variety of health issues but specify the behavioural components of individuals/groups with respect to seeking help/treatment or interventions used to maintain or promote their own health.</td>
</tr>
<tr>
<td>Health Status</td>
<td>The health issue discussed/mentioned is or relates to health status</td>
<td>The abstract/source mentions or discusses health status explicitly or mentions self-rated health of a population/group.</td>
</tr>
<tr>
<td>Hearing aids/Auditory evaluation</td>
<td>The intervention(s) mentioned include hearing aids or hearing evaluation</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions for hearing loss, in particular the evaluation for (i.e.</td>
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<tr>
<td>Code</td>
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</tr>
<tr>
<td>Hip Fracture</td>
<td>The health issue discussed/mentioned are hip fractures</td>
<td>This code is applied to abstracts/sources that discuss hip fractures and/or the challenges associated with it (and/or it’s treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Home Care</td>
<td>The intervention(s) mentioned include services provided to individuals in their homes/residences</td>
<td>This code is applied to sources/abstracts that mention/discuss home care services and the issues associated with their delivery and/or effectiveness as an intervention</td>
</tr>
<tr>
<td>Hospice</td>
<td>The intervention(s) mentioned include the use of a hospice</td>
<td>This code is applied to sources/abstracts that mention/discuss hospices as a treatment/intervention option at the end of life and/or the issues associated with their use (e.g. user or family experience) and/or provider perspectives</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Intervention for a health condition (or health related condition) for which hospital services were discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role hospital services (such as emergency room) and/or the situations in which this intervention would be considered part of the care strategy for an individual and/or his/her caregivers. While this code could be applied in conjunction with several other codes (e.g. surgery), it reflects the way in which use of the hospital for meeting many tertiary service requirements is communicated in the abstract and in particular whether the types of services situated in a hospital (other than Emergency Room visits) were either highlighted or not.</td>
</tr>
<tr>
<td>Incontinence</td>
<td>The health condition discussed/mentioned is incontinence (any type)</td>
<td>This code is applied to abstracts/sources that discuss incontinence and the challenges associated with it (and/or it's treatment or management) to the health</td>
</tr>
<tr>
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<tr>
<td><strong>Infectious Disease</strong></td>
<td>The health condition discussed/mentioned is infectious disease (of any type)</td>
<td>This code is applied to abstracts/sources that discuss infectious diseases and/or the challenges associated with them (and/or their treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Infectious Disease - HIV/AIDS</strong></td>
<td>The health condition discussed/mentioned is a specific type of infectious disease namely HIV/AIDS</td>
<td>This code is applied to abstracts/sources that discuss HIV/AIDS and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population. It is a sub-category of the infectious diseases category</td>
</tr>
<tr>
<td><strong>Infectious Disease - Influenza</strong></td>
<td>The health condition discussed/mentioned influenza</td>
<td>This code is applied to abstracts/sources that discuss influenza and/or the challenges associated with it (and/or it's treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Infectious Disease - Tuberculosis</strong></td>
<td>The health condition discussed/mentioned is tuberculosis</td>
<td>This code is applied to abstracts/sources that discuss tuberculosis in older adults and/or the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population. As it is a communicable disease, it was placed under in the category of infectious diseases.</td>
</tr>
<tr>
<td><strong>Informed Consent</strong></td>
<td>Intervention for a health condition (or health related condition) for which informed consent is considered</td>
<td>This code was applied to sources/abstracts that discussed the role of informed consent in care delivery and/or the situations in which this issue might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td><strong>Injury</strong></td>
<td>The health condition discussed/mentioned are injuries (of any type)</td>
<td>This code is applied to abstracts/sources that discuss injuries and the challenges associated with them (and/or their treatment or prevention) to the health and well being of an individual or a group/population.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>Instrumental/Activities of Daily Living</td>
<td>The health issue discussed/mentioned relates to the ability to conduct instrumental activities of daily living or activities of daily living. The challenges associated with the capacity (or impairment) to perform these activities and/or the impact to the health and well being of an individual or a group/population may also be discussed.</td>
<td>This code is applied to abstracts/sources that mention/discuss individuals’ ability to perform instrumental activities of daily living or activities of daily living. The challenges associated with the capacity (or impairment) to perform these activities and/or the impact to the health and well being of an individual or a group/population may also be discussed.</td>
</tr>
<tr>
<td>Intellectual Disabilities</td>
<td>The health condition discussed/mentioned is intellectual disability</td>
<td>This code is applied to abstracts/sources that discuss intellectual disabilities in older adults and/or the challenges associated with them to the health and well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Intervention for a health condition (or health related condition) that requires or is recommended to use an interpreter/translator</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of interpreters/translators and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>The health issue discussed/mentioned is life expectancy</td>
<td>This code is applied to abstracts/sources that discuss life expectancy and/or it's determinants and/or impact to the health and well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Loneliness/Isolation</td>
<td>The health condition discussed/mentioned is social isolation and/or loneliness</td>
<td>This code is applied to abstracts/sources that discuss social isolation/loneliness in older adults and the presence of/or risks for experiencing isolation or loneliness and the possible impacts on the health and well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Intervention for a health condition (or health related condition) for which nursing homes/long term care facilities</td>
<td>This code was applied to sources/abstracts that discussed nursing homes in particular as well as long-term care facilities, the types of care administered within them as these facilities.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Intervention for a health condition (or health related condition) for which mammography was considered appropriate</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of mammography and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers, in particular as a preventative measure in screening for breast cancer.</td>
</tr>
<tr>
<td>Medication</td>
<td>Intervention for a health condition (or health related condition) for which medication may be involved</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of medication and/or the impacts of their use as part of a care strategy for an individual.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Health Condition related to Mental Health</td>
<td>Abstracts/sources mentioning of conditions generally referred to as 'mental health', 'mental well being', 'mental health status' with or without reference to a specific subcategory of mental health condition (e.g. depression). Where there was a disorder mentioned, an effort was made to label it with the corresponding specific code, however there would be instances where the abstract would describe a specific condition and also talk about mental health/illness generally, in which case this code would also apply.</td>
</tr>
<tr>
<td>Mental Health - Abuse</td>
<td>A source that discusses abuse of older adults</td>
<td>This code is applied to abstracts/sources that discuss or mention abuse of older adults - including the many forms of abuse (e.g. physical, psychological) and the connection to/impact on health/well-being.</td>
</tr>
<tr>
<td>Mental Health - Bereavement</td>
<td>The health (or health related) issues related to bereavement</td>
<td>Source discusses the impact of bereavement on health/well-being - e.g. bereavement is associated with risk of</td>
</tr>
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<tr>
<td>Mental Health - Depression</td>
<td>Health Condition - Mental Health - Depression</td>
<td>This code is applied to abstracts/sources that discuss depression specifically and/or the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Mental Health - PTSD</td>
<td>The health condition discussed/mentioned is Post-traumatic stress disorder</td>
<td>This code is applied to abstracts/sources that discuss PTSD specifically and/or the challenges associated with it (and/or its treatment) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Mental Health - Suicide</td>
<td>The health issue discussed/mentioned is suicide</td>
<td>This code is applied to abstracts/sources that discuss suicide (attempted and completed) and the challenges associated with attempted suicide and/or its impact to the health and well being of an individual or a group/population and/or caregivers. Also, the topics of the impact of suicide completion on surviving older caregivers and family is covered by this code.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Intervention for a health condition (or health related condition) for which mental health services were used, recommended or discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of a variety of services termed mental health services and/or the situations in which theses intervention would be considered appropriate to the care strategy for an individual and/or his/her caregivers. There were a variety of terms used to describe &quot;mental health services&quot; from the actual term &quot;mental health services&quot; to specific types of services such as counseling or group therapies for mental health related conditions. Where appropriate, subtypes of services that were clearly mentioned were identified and codes applied (see psychotherapy).</td>
</tr>
<tr>
<td>Mental Health Services - Psychotherapy</td>
<td>Intervention for a health condition (or health related)</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of a</td>
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depression in late life
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<tr>
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<tbody>
<tr>
<td>Needs Assessment</td>
<td>Intervention for a health condition (or health related condition) for which a needs assessment was suggested or performed</td>
<td>This code was applied to sources/abstracts that discussed either the results of or recommended the use of a needs assessment in order to address gaps in understanding on key health or health related issues.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Interventions that address nutritional/dietary considerations</td>
<td>This code is applied to sources that mention or focus on interventions that speak to nutrition and diet and their impact on health and well being.</td>
</tr>
<tr>
<td>Obesity</td>
<td>The health condition discussed/mentioned is obesity</td>
<td>This code is applied to abstracts/sources that discuss obesity specifically and the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Oral Health</td>
<td>The health condition discussed/mentioned are considered to fall under 'oral health'</td>
<td>This code is applied to abstracts/sources that discuss issues or disorders/illnesses related to oral health and/or the challenges associated with them (and/or their treatment or prevention) to the health and well being of an individual or a group/population.</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>The health condition discussed/mentioned is osteoarthritis</td>
<td>This code is applied to abstracts/sources that discuss or mention osteoarthritis the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population.</td>
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<tr>
<td>Osteoporosis</td>
<td>The health condition discussed/mentioned is osteoporosis</td>
<td>This code is applied to abstracts/sources that discuss or mention osteoporosis and/or the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Pain</td>
<td>The health condition discussed/mentioned is pain</td>
<td>This code is applied to abstracts/sources that discuss or mention pain generally (i.e. not resulting from a specific illness or disorder) the challenges associated with it (and/or its treatment or prevention) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Palliative</td>
<td>Intervention for a health condition (or health related condition) for which palliative care was discussed or considered applicable</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of palliative care and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers, in particular for end of life care issues.</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>The health condition discussed/mentioned is Parkinson's disease</td>
<td>This code is applied to abstracts/sources that discuss or mention Parkinson's disease and/or the challenges associated with it (and/or its treatment) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td>Patient Centred Care</td>
<td>Intervention for a health condition (or health related condition) for which patient centred care was discussed</td>
<td>This code was applied to sources/abstracts that discussed the notion of patient centred care and/or the situations in which this intervention might be considered appropriate to the care strategy and outcomes for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Policy</td>
<td>Intervention for a health condition (or health related condition) for which a policy level action was discussed or recommended</td>
<td>This code was applied to sources/abstracts that discussed impact (actual or potential) that policy might be considered appropriate for. Policies that were already in place as well implications for policy that could possibly be developed were both included in this group.</td>
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<tr>
<td>Prevention</td>
<td>Interventions that refer to Illness/Disease Prevention</td>
<td>This code is applied to abstracts/sources that mention illness/disease prevention activities as a direct intervention or as part of recommendations/implications.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Intervention at the Primary Care level</td>
<td>This code is applied to sources/abstracts where the intervention refers to primary care, or the components of primary care including family physicians (general practitioners), community clinics (non-acute/non-tertiary)</td>
</tr>
<tr>
<td>Promotion</td>
<td>Interventions that are directly related to or characterized as being health promotion</td>
<td>This code is applied to abstracts/sources that mention health promotion activities as a direct intervention (e.g. education/awareness) or as part of recommendations/implications.</td>
</tr>
<tr>
<td>Reminiscence Therapy</td>
<td>Intervention for a health condition (or health related condition) for which Reminiscence Therapy was considered appropriate</td>
<td>This code was applied to sources/abstracts that discussed the use of/role or potential for benefit of Reminiscence Therapy and/or the situations in which this intervention would be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
<td>Research</td>
<td>Intervention for a health condition (or health related condition) for which researching ethnocultural minority older adults was discussed or recommended</td>
<td>This code was applied to sources/abstracts that discussed the research process or called for additional development of research with respect to ethnocultural minority older adults. The situations in which research has been conducted, the barriers/determinants of quality research as well as the operational considerations are discussed in this group.</td>
</tr>
<tr>
<td>Resilience</td>
<td>The health issue discussed/mentioned is resilience</td>
<td>This code is applied to abstracts/sources that discuss or mention resilience and/or the factors/determinants that encourage or promote it as well as its influence on the health and well being of an individual or a group/population in confronting and/or managing illness</td>
</tr>
<tr>
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<tr>
<td><strong>Screening - Scales</strong></td>
<td>Intervention for a health condition (or health related condition) for which screening using a specific scale was discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of specific diagnostic scales and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. Many of the scales referenced using this code speak to the use of culturally appropriate scales and/or ways in which to measure health conditions reliably using translated versions of existing scales.</td>
</tr>
<tr>
<td><strong>Sensory Loss</strong></td>
<td>The health condition discussed/mentioned is sensory loss</td>
<td>This code is applied to sources/abstracts that mention or focus on sensory loss or decline (as well as impairment) and is referred to specifically as such by the author. Although it is recognized as a component of aging, all types of sensory loss (not including cognitive impairment/decline) were considered, such as declining vision or hearing. Abstracts/sources may speak to challenges associated with various types of sensory loss (and/or its treatment or management) to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Sleep Disorders</strong></td>
<td>The health conditions discussed/mentioned are sleep related disorders</td>
<td>This code is applied to abstracts/sources that discuss sleep disorders in older adults and/or the challenges associated with them to the health and well being of an individual or a group/population</td>
</tr>
<tr>
<td><strong>Social Care</strong></td>
<td>Intervention for a health condition (or health related condition) for which social care was discussed</td>
<td>Abstracts/sources that mention using 'social care' or sources of care from those around an individual such as family, friends or social networks.</td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
<td>Intervention for a health condition (or health related condition) for which social work was discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of social work and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Spiritual</td>
<td>Intervention for a health condition (or health related condition) for which some type of spiritual therapy was discussed</td>
<td>This code was applied to sources/abstracts that discussed the use or the role of spiritual interventions (i.e. characterized as spiritual by the authors of the abstract) and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. The contextualization of faith based or spiritually based perspectives and their relationship to health, specifically at the intervention level.</td>
</tr>
<tr>
<td>Surgical</td>
<td>Intervention for a health condition (or health related condition) for which surgery or surgical procedures were discussed</td>
<td>This code was applied to sources/abstracts that discussed surgery or surgical interventions and/or the situations in which this intervention might be considered appropriate to the care strategy for an individual and/or his/her caregivers. Issues arising from the consideration of surgery as an intervention also were coded using this category.</td>
</tr>
<tr>
<td>Traditional Medicine/Complementary &amp; Alternative Medicine</td>
<td>The intervention(s) mentioned include treatments considered to be traditional&quot; or &quot;folk&quot; or complimentary or alternative medicine</td>
<td>This code is applied to sources/abstracts that mention/discuss treatments/interventions that are considered to be traditional (e.g. &quot;traditional Chinese&quot; medicine) and/or complimentary/alternative medicine. While it is recognized that not all types of traditional medicine/interventions are considered &quot;CAM&quot; per se, the use of 'alternate systems of health' contained in the definition of CAM does overlap significantly with the use of ethnoculturally 'traditional' systems/interventions.</td>
</tr>
<tr>
<td>Transplantation</td>
<td>Intervention for a health condition (or health related condition) for which organ transplantation/donation were discussed</td>
<td>This code was applied to sources/abstracts that discussed organ transplantation/donation and the situations in which this intervention formed part of a care strategy (or options for care) for an individual and/or his/her caregivers.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Well Being</strong></td>
<td>Health Condition - Well Being</td>
<td>This code was applied to abstracts that mentioned “well being” specifically or &quot;quality of life&quot; that included the topics of well being and/or health/wellness.</td>
</tr>
</tbody>
</table>