Filipino Formal Caregivers to the Elderly and Normalized Exploitation in the Workplace

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ABSTRACT. In this paper, we argue that a caregiver's sociocultural contexts including the labor conditions in a privatized US eldercare industry and transnational obligations to families in the Philippines shape how they perceive their health as it is associated with their formal caregiving work. We build on extant literature reporting on the exploitative work conditions of formal Filipino caregivers. In a mixed-methods study, we find that Filipino/a formal caregivers normalize exploitation in their work with elderly patients because of sociocultural contexts. Additionally, caregivers' self-perception of mental health underrepresents their mental health symptoms because of their structural positions as precarious workers and migrants with transnational family dependents.

As the Baby Boomer generation (born between 1946–1964) continues to need specialized care in their post-retirement years, the care crisis balloons in the United States (US). The demand for caregivers for the elderly is at an all-time high. The lack of a federally-funded system to provide long-term care for the aging population in countries like the US and Canada has ushered in the growth of for-profit long-term residential care facilities.[1] After the 1965 passage of the Medicare and Medicaid programs in the US that only pays for short-term care for the aged and disabled, privatized nursing homes for long-term care increased alongside the increasing needs of aging Americans.[2] Many Filipino/a migrant caregivers have answered the call as "formal care workers" in long-term care facilities. Formal care workers or caregivers are paid for their work, as opposed to informal caregivers, who are unpaid for the care they provide to their family members or friends.[3] The aim of this article is to examine the implications of the characteristics of a privat-

1. Pat Armstrong, Hugh Armstrong, Martha MacDonald, and Malcolm Doupe, "Privatization of Long-term Residential Care in Canada: The Case of Three provinces." The Privatization of Care: The Case of Nursing Homes, no. 1 (2020): 87-101.
2. Charlene Harrington, Allyson M. Pollock and Shailen Sutaria, "Privatization of Nursing Homes in the United Kingdom and the United States," The Privatization of Care: The Case of Nursing Homes, no. 1 (2020): 51-67.
3. Kevin Riley, Jennifer Nazareno and Sterling Malish, "24-Hour Care: Work and Sleep Conditions of Migrant Filipino Live-in Caregivers in Los Angeles," American Journal of Industrial Medicine 59 (2016): 1120-1129, doi:10.1002/ajim.22647.

ized eldercare industry in the US on the work conditions of Filipino caregivers in the US. We argue that the sociocultural contexts of Filipino caregivers—as Filipino migrant workers with transnational ties to the Philippines—produce a normalization of exploitation in their workplace.

Historically, the privatization of the eldercare industry in the US was a neoliberal response to the inability of the US government to provide ample government spending towards a swelling aging population.[4] It follows that the rapid expansion of residential care facilities for the elderly (RCFE) has seen little governmental regulation, shifting the responsibility for its patients and workers largely to the private owners and employers of the eldercare workers. Formal caregivers' employment arrangements range from one-on-one care, both full time and part time, to working in multiple bed RCFEs. With the variance in caregiver arrangements, the possibilities for exploitation and abuse is expansive. From verbal and emotional abuse, labor exploitation, isolation, retaliation, and wage theft, the lack of labor standard regulation leaves caregivers vulnerable. While the privatized industry of eldercare is booming, the oversight to ensure workers have basic labor protections in the workplace are weak.

For Filipino migrants, securing work as a caregiver can come through different avenues, but one avenue migrants rely on are the social immigrant networks in the cities they migrate to. The expansion in privatized eldercare after 1965 converged with the opening up of the immigration quotas for countries like the Philippines that ushered in concentrated destination cities in the US.[5] The San Francisco/Bay Area, a traditional port city for Filipino immigrants, with the highest concentration of Filipino Americans in the US, has become a reliable starting place for Filipino migrants to search and find work in industries such as eldercare. Filipino migrants filled the labor shortages in industries like nursing, teaching, and eldercare. For newly arrived Filipinos, work opportunities in caregiving travels through word of mouth in social immigrant networks; and with minimal qualifications required, Filipino migrants can use caregiving to accrue the capital they were in search of through labor migration.

Many Filipino migrants find work at RCFEs which are non-medical facilities that provide minimal care and assistance with daily living activities for persons 60 years of age or older. Caregivers work as both live-out and live-in caregivers, the latter requiring them to live and work at the same facility. Formal caregivers' work consists of helping with activities such as bathing, grooming, toileting, laundry, feeding, cooking, ambulation assistance, house cleaning, sanctioned medical

4. Charlene Harrington, Allyson M. Pollock, and Shailen Sutaria, "Privatization of Nursing Homes," 54.

5. Rick Bonus, Locating Filipino Americans: Ethnicity and the Cultural Politics of Space. Vol. 216. (Philadelphia: Temple University Press, 2020); Benito M. Vergara, Pinoy Capital: The Filipino Nation in Daly City (Philadelphia: Temple University Press, 2009).

care, patient lifting, and basic companionship.[6] In California, there are no specific staff-to-patient ratios, only a mandate for RCFE owners to provide "adequate" staffing. Reports have established that the RCFE model of long term care for the elderly has poor inspection frequency which can result in deleterious effects for both caregivers and their patients.[7] Multiple tenets of the Fair Labor Standards Act (FLSA) are frequently violated by RCFEs through denying workers' wages, forcing caregivers to work beyond eight hours, even as staff-patient ratios increase in RCFEs, while complaints about care in RCFEs are often lost in a broken complaint system.[8] Although all care workers are covered under minimum wage and overtime pay protections, caregivers can work over 12 hours a day without proper meal and rest breaks and interrupted sleep in RCFEs.[9] Many Filipino caregivers often endure difficult work conditions in RCFEs to support their families in the US and in the Philippines.[10] Both social indebtedness to the immigrants who helped them get their jobs and high financial debt to recruitment agencies or lenders that facilitated their migration put caregivers in precarious positions. These sociocultural contexts and the caregiving industry's lax regulatory measures place Filipino workers in the caregiving industry at an elevated risk of poor health outcomes for themselves *and* those for whom they provide care.

To this end, the goal of this study was to build on extant literature reporting on the exploitative work conditions of formal Filipino caregivers. Yet, we aim to expand the understanding of precarity in caregiving to include sociocultural and transnational contexts that inform Filipino migrants' decisions to continue working as caregivers under, at times, dangerous conditions. Moreover, this paper is an effort to explore mental health outcomes such as stress and fatigue as a product of the aforementioned labor conditions and sociocultural contexts. We advance these research questions: (1) What sociocultural contexts inform formal Filipino caregivers' work conditions? (2) Under what conditions do formal Filipino caregivers experience stress at work? From a mixed-methods study with a survey N=114 and 19 interviews with Filipino caregivers in the San Francisco/Bay Area, we argue that a caregiver's sociocultural contexts, including labor conditions in a privatized US eldercare industry and transnational obligations to families in the Philippines, shape how they perceive their health as it is

6. Occupational Safety and Health Administration, "Guidelines for Nursing Homes Ergonomics for the Prevention of Musculoskeletal Disorders," (2009). https://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.pdf
7. Hina B. Shah, "Understaffed and Overworked: Poor Working Conditions and Quality of Care in Residential Care Facilities for the Elderly," Publications (2017):788. https://digitalcommons.law.ggu.edu/pubs/788
8. California Advocates for Nursing Home Reform, Residential Care in California: Unsafe, Unregulated & Unaccountable (San Francisco, CA, 2013), http://www.canhr.org/reports/2013/Residential_Care_in_California.pdf.
9. Kevin Riley, Jennifer Nazareno, and Sterling Malish, "24-hour care," 1123.
10. Charlene Tung, "The Cost of Caring: The Social Reproductive Labor of Filipina Live-in Home Health Caregivers," Frontiers 21, no 1-2 (2000): 61-82, doi: 10.2307/3347032.

associated with their formal caregiving work. This paper contributes to Filipinx American Studies that insist on Filipinos' transnational lives as a key feature of their perceptions of mental and physical health. Our hopes are that the findings in this study will assist individuals, organizations, and policymakers in reviewing the labor standards in eldercare to eventually provide dignified and respectable work conditions for Filipino caregivers.

Methodology: Sociocultural Contexts in Surveys and Kuwentuhan

Methodological Frameworks

Filipinx American scholars have established that the Philippine state has and continues to pursue labor migration as a cornerstone to the nation's economic viability.[11] We assert that the production of migrants as an export also shapes the work ethic of Filipina/o caregivers when they are abroad. The reasoning for their labor migration often centers on the betterment of their families' future; therefore, they strive to maximize economic and social opportunities abroad. This aspiration for familial uplift also informs how Filipina/o caregivers approach their work as the centrality of family relations, for their posterity and their elders alike, extends to their high valuation of elder care in their occupation. Complementarily, upon their arrival to the US employers often attribute immigrant work ethics as a "cultural" element.[12] For both Filipino caregivers and their employers, the narrative that Filipino immigrants are "hard workers" and naturally attuned to caregiving work is present. And yet, we recognize that this echoes long-standing inequities in the American racial order wherein employers across industries have pegged immigrant work ethics against African American workers.[13] In fact, studies have shown that not only do racial and cultural backgrounds shape caregivers' work, Filipina/o migrant caregivers' experience as care workers are shaped by racialized stigma against immigrants and structural barriers to legal and work status.[14]

Given this context, we draw from the theoretical framework developed by African American Studies scholars and scholars from

11. Robyn Magalit Rodriguez, Migrants for Export: How the Philippine State Brokers Labor to the World (Minneapolis; London: University of Minnesota Press, 2010); Anna Romina Guevarra, Marketing Dreams, Manufacturing Heroes: The Transnational Labor Brokering of Filipino Workers (New Brunswick, New Jersey; London: Rutgers University Press, 2010).
12. Ruth Gomberg-Muñoz, "Willing to Work: Agency and Vulnerability in an Undocumented Immigrant Network," American Anthropologist 112 no. 2 (2011): 295-307. http://www.jstor.org/stable/40801781.
13. Philip Moss and Chris Tilly, Stories Employers Tell: Race, Skill, and Hiring in America (New York, Russell Sage Foundation, 2001).
14. Valerie Francisco-Menchavez, The Labor of Care: Filipina Migrants and Transnational Families in the Digital Age (University of Illinois Press, 2018); Ethel Tungohan et al., "After the live-in caregiver program: Filipina caregivers' experiences of graduated and uneven citizenship," Canadian Ethnic Studies 47, no. 1 (2015): 87-105.

the Asia-Pacific to capture both race and ethnic specificity of working in the US and the transnational considerations for migrant workers. We rely on African American Studies scholars Dilworth-Anderson and Anderson who propose that the emotional distress that informal African American caregivers incur must be analyzed through the frameworks of the "sociocultural, situational, interpersonal, temporal and personal contexts in which they give care."[15] In fact, they argue that racial ethnic contexts have direct influences on how caregivers provide care and if interventions are proposed to ameliorate the negative emotional effects of caregiving. For example, since African American women believe that caregiving of their elderly family members is a part of their familial obligation, they create social support networks to attend to their responsibilities.[16] In this way, race and ethnic backgrounds may buffer the mental health stressors of caregiving in African American communities, but it may also obscure the strains of attending to a family member's health. In the main, this framework advances the importance of "sociocultural contexts," or in other words, the cultural beliefs and attitudes of caregivers towards providing care to elders. Similarly, we underscore that Filipino sociocultural contexts must be incorporated into the analysis of formal Filipino caregivers' work and health outcomes. For example, cultural values like "*utang ng loob*,"[17] translated as social reciprocity, and "*tiis*" translated as persistence, assist us in understanding the work ethic of Filipino caregivers and their mental health outcomes. These Filipino values that often rely on familial dynamics can determine the nature of caregivers' work behaviors.

Still, it is important to maintain how transnational aspects of their lives affect their experience as migrant workers. Scholars working on transnational experiences of migrant workers in the Asia-Pacific, Dutta et al., argue that migrant care workers' health issues are minimized because of the transient nature of their work.[18] Their commitments to their families abroad coupled with lack of access to health services to migrant workers further exacerbate their negative health outcomes. Dutta et al. argues a "culture-centered approach"[19] to researching the health outcomes of migrant care workers must take into account both cultural and structural conditions that influence their health, which includes their transnational obligations to families at home and marginalization as migrant workers. In their words, "health

15. Peggy Dilworth-Anderson, Sharon W. Williams, and Theresa Cooper, "The Contexts of Experiencing Emotional Distress among Family Caregivers to Elderly African Americans," Family Relations 48, no. 4 (1999): 391-396, doi:10.2307/585246.
16. Peggy Dilworth-Anderson, Sharon W. Williams, and Theresa Cooper, "The Contexts of Experiencing Emotional Distress," 396.
17. Kevin L. Nadal, Filipino American Psychology: A Handbook of Theory, Research, and Clinical Practice (Hoboken, John Wiley & Sons Inc., 2011).
18. Mohan J. Dutta et al. "Health Meanings Among Foreign Domestic Workers in Singapore:A Culture Centered Approach," Health Communication 33, no. 5 (2018): 643-652, doi: 10.1080/10410236.2017.1292576.
19. Dutta, "Health Meanings," 645.

behaviors need to be understood in terms of their structural determinants instead of studying isolated, individual actions".[20]

We bridge these frameworks together to study Filipino caregivers' health outcomes as they construct their ideas of care to their patients locally, while moored to their transnational ties to the Philippines. The sociocultural contexts in the US and a transnational culture-centered approach allows us to stitch together the racialized and gendered precarity of caregiving in the US while holding in tension the importance of transnational life for Filipino migrants. We bring these frameworks together to examine the geographic scales that Filipino migrants' lives operate under. As we submit in this paper, these scales can be one way to understand how Filipino caregivers attend to their mental health.

Methods

Beginning in 2017 and ending in 2019, the first phase of this mixed-methods study aimed to examine physical and mental health outcomes among Filipino caregivers in the San Francisco/Bay Area. Through survey research, we collected information about formal Filipino caregivers' work conditions such as types of daily living assistance tasks, hours of work, wages, access to wages, deductions, meal and rest breaks, sick leave, access to health insurance and vacation days, or lack thereof. We measured stress levels[21] in the same survey to capture caregivers' perceptions of their physical and mental health status and their appraisal of the impact caregiving work had on their emotional life. However, since there is a dearth of validated measures on cultural values of formal caregivers, we included questions on sociocultural contexts[22] for Filipino labor migration such as migrating abroad to secure a better future for families in the Philippines.

We used a method of *kuwentuhan*,[23] a Philippine cultural practice of storytelling that can facilitate the exchange of essential information among its participants. In kuwentuhan, a semi-structured guide was followed but the conversation relied mainly on the Filipino cultural value of talk-story wherein participants could pick up and expound on themes that they deemed important. In kuwentuhan, researchers could

20. Dutta, "Health Meanings," 645.

21. Paul A. Pilkonis et al., "Item Banks for Measuring Emotional Distress from the Patient-Reported Outcomes Measurement Information System (PROMIS): Depression, Anxiety, and Anger," Assessment 18, no. 3 (2011): 263-283, doi:10.1177/1073191111411667; Judith R. Gordon et al, "Balancing caregiving and work: Role conflict and role strain dynamics," Journal of Family Issues 33, no. 5 (2012): 662-689, doi: 10.1177/0192513X11425322.

22. Family Caregiver Alliance, "Uniform Assessment Tool." California Caregiver Resource Center, (2012). https://caregiver.org/caregiver/jsp/content/pdfs/tk_california_assessment_tool.pdf

23. Valerie Francisco, "Ang Ating iisang Kuwento" Our Collective Story: Migrant Filipino Workers and Participatory Action Research," Action Research 12, no. 1 (2014): 78-93. https://doi.org/10.1177/1476750313515283

explore deeply how Filipino care workers come to understand and act on their health behaviors at their workplace and in their lives, more broadly. In kuwentuhan that lasted anywhere between 45 minutes to an hour, we explored the influence of respect for the elderly, immigrant social networks, and Filipino cultural values such as "*utang ng loob*" (translated as social reciprocity) on caregivers' approaches to their work and, more importantly, to their health behaviors while caregiving. We have collected a total of 19 kuwentuhans.

Our sample comprises 114 care workers who lived in the San Francisco/Bay Area, ages ranging from 18 to 85, who answered the surveys and interviews. Among the participants, 78.6% self-identified as women and 21.4% as men. Participants self-identified 82.6% as Filipinos/as and 15.1% Filipino/a Americans, the latter demarcated if the person was born in the United States. The average time caregivers in this study lived in the US is 16.2 years (see Table 1). We have begun a second phase of this study after the COVID-19 pandemic began and we continue to collect surveys and kuwentuhan on these measures with additional attention to the work conditions produced by the pandemic.

Table 1. Sample of Filipino/a Formal Caregivers (N = 114)

Characteristics	*n* (%)	M (SD)
Mean age range (Years)		45 - 54 (1.7)
Education		
Less than high school	2 (2.3)	
High School	19 (22.1)	
1-3 years of college	31 (36.1)	
>4 years of college	34 (39.5)	
Immigrant		
Yes	71 (82.6)	
No	15 (17.4)	
Identify as:		
Filipino/a	71 (82.6)	
Filipino/a American	13 (15.1)	
Other	2 (2.3)	
Gender		
Woman	66 (78.6)	
Man	18 (21.4)	
Mean years lived in U.S.		16

Contexts: Transnational Obligations, Eldercare Crisis and Filipino Work Ethic

Although the Filipino migrant community are upheld as highly educated and upwardly mobile professionals,[24] many who enter with non-professional visas and contracts are funneled into the caregiving industry through social immigrant networks. A popular narrative

24. Alejandro Portes and Rubén G. Rumbaut, Immigrant America: A Portrait (Berkeley: University of California Press, 1990).

circulated about Filipino caregivers regards their respectable work ethic and commitment to their patients as their key characteristic.[25] Work ethic implies a standard of work behavior adopted by a worker to excel at their occupation, thus providing the worker entitlement to their wage. For immigrants, work ethic is reified as a natural racial, ethnic or cultural trait or norm, yet this problematic idea does not take into account specific sociocultural contexts of the work conditions of migrant workers. We examine how a Filipino caregiver's work ethic transforms into a normalization of exploitation in caregiving. In the following section, we examine the coercive dynamics of transnational pressures on migrant workers, combined with the rapacious nature of caregiving work and RCFE's non-enforcement of labor standards, which produces the normalization of exploitation for Filipino caregivers.

Our study shows that 59.5% of participants reported that their families in the Philippines rely on their income for basic living needs (see Table 2).

Table 2. Transnational and Sociocultural Contexts for Migration Among Filipino/a Caregivers (N = 114)

Characteristics	n (%)
Reason for migration (Very Important)	
To find employment or a job.	70 (85.4)
To join other family members.	54 (86.6)
To improve the future of the children in the family.	70 (84.3)
To improve your life or that of your family and look for better opportunities.	73 (88)
Because of the political situation in your country of origin.	16 (19.8)
You or your family were persecuted for political reasons.	8 (9.8)
To seek medical attention.	25 (30.5)
To seek better educational opportunities.	52 (64.3)
Because of marital or family problems.	14 (17.07)
Felt strained between work and family responsibilities.	50 (59.5)

In a list of reasons about their motivations for migration, 88% of caregivers in this study articulate their migration as a way to improve their families' lives in the Philippines while searching for better opportunities in the US. Of our participants, 85.4% report that their migration to the US was based on finding employment. In kuwentuhan, when asked about her family in the Philippines and how it relates to her work consecutively for many months, 55-year old Hester, a caregiver supporting two children in the Philippines, said, "There's a saying, 'You can't get sick,' diba? Not that you won't, but you can't, right? That's a sacrifice you promised to yourself and your family." Here, we note that these transnational conditions are not separate from how Filipino migrants approach

25. Charlene Tung, "The Cost of Caring," 63.

their health and work in the US. Not only have their labor migrations, prior to working in the US, as well as *in* the US, required them to incur great debt, the livelihood of their families depend on them showing up at their caregiver job daily. We submit that these transnational contexts produce conditions wherein Filipino migrants are eager to earn a wage, and caregiving is an easy job to get in the glut of elder care workers. Moreover, we find that these transnational obligations are coupled with an unregulated American eldercare industry.

Caregiving has a high demand for care workers yet is an invisible industry given that the work of caregiving occurs in private homes and privatized RCFEs. This makes caregiving a prime precarious occupation because of its "hidden" nature allowing for labor standards to be ignored and while giving immigrants with various legal statuses an ability to work.[26] Finally, as an ethnic labor niche for Filipinos in the San Francisco/Bay Area, elder care consumers (whether at an RCFE or one-on-one) have an expectation that there is an abundance of Filipino migrant workers in the area, which adds to the notion that they are disposable. The sociocultural context of a privatized eldercare industry alongside a racialized and precarious workforce in Filipino migrants produce what we are calling "normalized exploitation" for Filipinos/as caregivers. We define this concept as caregivers normalize their work conditions as nonstop and the tempo of a work day is not amenable to rest or meal breaks. Contrary to the California Domestic Workers Bill of Rights,[27] which mandates 10 minutes of uninterrupted break for every 4 hours of work, our study finds that caregivers get an average minimum of 20 minutes of break time during a 9-hour work day. Way below the state mandate, caregivers are clocking in an average of 8 minutes per 4 hours of work. Additionally, our study demonstrates that 64.5% of caregivers have their breaks interrupted and 56% of caregivers have their sleep interrupted (see Table 3).

Normalized Exploitation: Around the Clock Work and Multiple Caregiving Jobs

Our research confirms the existing scholarship that live-in caregivers' work environment and demands are onerous and difficult, which can result in serious health risks.[28] Riley et al. finds that "A live-in caregiver may effectively work up to 24 hours per day depending on the

26. Jennifer P. Nazareno, Rhacel S., Parreñas, and Yu-Kang Fan, Can I Ever Retire? The Plight of Migrant Filipino Elderly Caregivers in Los Angeles (Los Angeles: UCLA Institute for Research on Labor and Employment, 2014), https://escholarship.org/uc/item/0zj455z5.
27. The Domestic Worker Bill of Rights, Cal. Assemb. B. 241, Chapter 374 (Cal. Stat. 2014).
28. Daniela Delgado, "The Health Impacts of Domestic Labor on Women Workers in Massachusetts," (PhD diss., Harvard Medical School, 2017).

Table 3. Current Caregiver Work Conditions in RCFEs for Filipino/a Caregivers (N = 114)

Work Conditions	*n* (%)	M (SD)
Mean break time (Minutes)		20 (2.3)
Stopped break to attend to work	58 (64.5)	
Break was cut short	58 (63.1)	
Stopped break to do work	58 (64.5)	
Not allowed to leave the worksite during the break	45 (48.9)	
If live-in, sleep was interrupted	28 (56)	
How many patients do you care for in a day?		
1-4	57 (61.3)	
5-8	19 (20.4)	
9 or more	17 (18.3)	
Amount of caregiver jobs they currently have		
0 (Former caregivers)	17 (18.3)	
1	39 (41.9)	
2	24 (25.8)	
3	8 (8.6)	
4	1 (1.1)	
5	5 (4.3)	
How many locations does your current/most recent employer have?		
1	42(47.7)	
2	20 (22.7)	
3	8 (9.1)	

patient's health status and care needs."[29] Our study verifies that multiple demands on caregivers during their work day affect their rest and sleep.[30] Live-in caregivers in our study reported that they feel that they are on call duty when they are on and off the clock, never feeling entitled to a break. In caregiving occupations, working overtime is sometimes necessary to fulfill patient needs, despite its detrimental mental and physical health effects on caregivers. When caregivers are unable to tend to urgent tasks while on break or stay over their work schedule, they are left feeling guilty about not being able to care for their patients while also frustrated about their inability to negotiate the work hours.[31]

When asked about taking a meal or rest break, Serena, a 46-year-old veteran caregiver of 16 years in an RCFE says, "Yes but if they needed you, you'd have to go. Yeah, it's like we're there to be

29. Kevin Riley, Jennifer Nazareno and Sterling Malish, "24-hour care," 1121.
30. Clare L. Stacey, "Finding Dignity in Dirty Work: The Constraints and Rewards of Low-wage Home Care Labour," Sociology of Health & Illness 27 (2005): 831-854, doi:10.1111/j.1467-9566.2005.00476.x; Pia Markkanen et al., "There's No Place Like Home: A Qualitative Study of the Working Conditions of Home Healthcare Providers," Journal of Occupational and Environmental Medicine 49 (2007): 327-337, doi: 10.1097/JOM.0b013e3180326552; Kevin Riley, Jennifer Nazareno and Sterling Malish, "24-hour care"; Linda Burnham and Nik Theodore, Home Economics: The Invisible and Unregulated World of Domestic Work (New York: National Domestic Workers Alliance, 2012), doi:10.13140/RG.2.1.4018.6648.
31. Susan Braedley et al., "We're told, 'Suck it up': Long-Term Care Workers' Psychological Health and Safety," Ageing International 43 (2018): 91–109, https://doi org.jpllnet.sfsu.edu/10.1007/s12126-017-9288-4.

there all the time." According to our results, 56.5% of caregivers had their meal breaks cut short and 59% kept working during it. Echoing the statistical evidence in our study, Serena's interview affirms the fact that caregivers feel as if their time on-duty means that they cannot effectively rest during their workday. Tina, a 53-year-old caregiver in a four-bed facility responded to this same query with, "Yeah, because it depends on the patient. And like you can't cut out a patient just because of a break, it's just like a kid when your child needs something." Tina who has left children and parents behind in the Philippines often referred to her own family throughout her interview while exploring her work ethic. Tina's response demonstrates how caregivers interpret the pressure to work through their rest breaks due to the needs of their patient informed by their high value in caring for family members or "familism." The concept of familism refers to "the normative commitment to immediate and extended family . . . which supersedes the individual."[32] While the demands of elderly patients normalize caregivers to be under round-the-clock work conditions, caregivers draw from their ideas of familism to dismiss a break during the work day, even if it is stipulated by statewide policies. We highlight this concept of familism to point out that much of caregivers' work draws from their own cultural and significant valuation of family in the construction and practice of a relentless work ethic. While their families may be in the Philippines or in the local Bay Area, similar to African American informal caregivers, their regard for their patients converges with their cultural attitudes about caring for biological kin.

Still, we want to be careful here and note that the normalization of exploitation and a caregiver's work ethic is not only an individual decision of caregivers to be altruistic. Rather it is the nature of the work of caregiving and the structural understaffing of RCFEs that disallows caregivers to assert their rights to a break. While caregivers use familism to inform their relationship with patients, their work ethic is constrained by the insecurity of working in a privatized elder care industry: from the low hourly wages in RCFEs that often compel migrants to take on "part-time" jobs as one-on-one caregivers on their days off to the consistent vague terms of staffing in private RCFEs. 71% of caregivers in this study reported that they had worked one to two caregiver jobs, 13% work three to four caregiver jobs, and 15% have worked five or more caregiver jobs in the last five years. On average, the participants have worked as a caregiver for about five to seven years (see Table 4). Additionally, given the spread-out geography of the Bay Area, 39.8% caregivers have to juggle multiple jobs and commuting to maintain a living wage. Caregivers' multiple jobs can render caregivers susceptible to many types of exploitation across their jobs. But more importantly, that a single caregiving job cannot support their basic

32. Heather R. Fuller-Iglesias and Toni C. Antonucci, "Familism, Social Network Characteristics, and Well-being Among Older Adults in Mexico," Journal of Cross-Cultural Gerontology 31 (2016): 2, doi: 10.1007/s10823-015-9278-5.

Table 4. Caregiving Employment History N =114

Characteristics	*n* (%)	M (SD
Mean length worked as a caregiver (years)		5-7 (1.5)
Years worked as a caregiver		
Less than 1 year	10 (11.1)	
2 – 4 years	26 (28.9)	
5 – 7 years	16 (17.8)	
8 – 10 years	17 (18.9)	
11 – 15 years	12 (13.3)	
More than 15 years	9 (10)	
Number of employers they worked for in the last five years		
1-2	64 (71.1)	
3-4	12 (13.3)	
5+	14 (15.5)	
Length worked for current/most recent employer		
Less than a year	20 (21.5)	
1-5 years	58 (62.4)	
6-10 years	10 (10.8)	
11-15 years	5 (5.4)	

needs becomes a key feature in their vulnerability to a range of work-place abuses.

While the narrative of Filipino caregivers can be told through their hard work and persistence, the crisis in elder care in the US recasts Filipino migrant workers' work ethic as a process of normalized exploitation. Because Filipinos hold so many jobs as caregivers, with a mix of full-time and part-time arrangements, they interpret their ability to cope with physical demands of their work as a part of their work. A second illustration of normalized exploitation is caregivers' articulation of exhaustion and physical injury under pressure. When Hester, a 55-year old caregiver with 10 years of experience, was asked to assess the workload of caregiving, she replied with, "It's burnout. Well, we get hurt every day, you really can't stay away from it. Especially when you have a client who's really active . . . When he grabs you, scratches you. It's included in the job." Hester's quote demonstrates that physical pain and injury is an acceptable part of her job and is unavoidable. Similarly,

Richelle, a 53-year old caregiver who has worked at the same RCFE for 8 years, stated,

> I twisted my knee and I didn't know it. So I mean you get, you can't help it. It's the nature of the job. It's the nature of the job, we don't do like, totally lift them up, like that. But whenever we assist, even if you do bodily economics, you're really bound to hurt yourself. It's the wear and tear. You know, if you keep on

> doing something like over and over again, you're bound to, you know, burn out, have an injury, one or two injuries, minor but yeah. Sad but yeah nothing you can ever prevent that. We are still paid at the end of the day.

Richelle and Hester demonstrate that they are aware of the risks of their work as caregivers and yet they minimize the physical and mental consequences of their work. Their mention of the world "burnout" proves that they are conscious of their exhaustion, yet they understand this aspect of their work as part of their job. And while burnout can present with symptoms of depression such as "difficulty starting or finishing things," Filipino caregivers do not identify their burnout with this mental health condition.

Jomar, a 44-year-old caregiver who has been working in the industry with multiple jobs for 5 years, was asked if he feels stressed while working. He expressed, "Not really stressed, just overworked, really tired. Over fatigued." Tina, whom we referred to earlier, was asked if she ever felt exhausted, to which she responded, "Mm no . . . maybe tired, a little bit. But you're here to work so no matter what you have to. You're paid for that." These examples demonstrate that the physicality and emotional toll of caregiving becomes an occupational hazard, often mitigated by caregivers' wages. The recurring theme regarding various levels of stress and exhaustion exemplified by these excerpts show is that many caregivers understand fatigue and injury to be part of their job, thus leading them to downplaying possible emergent mental health issues. We want to emphasize that Filipino caregivers' work ethic isn't the only reason why they might not identify their mental health issues, rather it is the lax regulations in RCFEs that do not offer a living wage and proper staff support during shifts that put caregivers at risk. In sum, normalized exploitation in the caregiving industry compels caregivers to tolerate physical and/or emotional exhaustion to fulfill their financial needs.

Interpreting Filipino Caregivers' Self-Perceptions of Mental Health

Even with caregivers explicitly discussing normalized exploitative work conditions in our kuwentuhan, our survey produced mixed findings about caregivers' self-perceived health outcomes. When asked about the status of their emotional and physical health as a caregiver, results indicate caregivers appear to be emotionally healthy. On validated measures for stress indicators in the general category of care workers in the US, 59.5% self-reported various symptoms of emotional exhaustion and 35.1% self-reported that they had difficulty making decisions. The lack of significance in these results do not support the finding that poor working conditions negatively affect the mental health

of care workers.[33] However, the data also shows that 68.7 % of caregivers reported feeling ill and 52.4% reported feeling overwhelmed. We propose that lack of significance and inconsistency in the data could be attributed to perceptions of stress impacted by sociocultural factors and transnational contexts. Drawing from the "culture-centered approach" of Dutta et al.,[34] we interpret these mixed findings as migrant care workers underrepresenting their stress and health ailments because they are precarious workers and migrants with transnational family dependents. Past studies found that Filipinos do not identify their mental stressors as mental health issues until they have escalated into suicide and depression.[35] Filipino cultural values such as *tiis*, or persistence, alongside Filipino familism, explains why caregivers underplay symptoms of mental health, since it puts primacy on their ability to support their families financially, rather than recognizing initial feelings of stress and exhaustion. Therefore, while they may feel stressed, exhausted, and depression derived from their work conditions, Filipino caregivers may not label their symptoms as such given the sacrifice they are making for their families' well-being.

What we are missing from self-reported health outcomes, we can analyze with caregivers' kuwentuhan about the transnational and cultural contexts of their lives. We find that the measures in the survey does not adequately attune to certain sociocultural norms and Filipino/a cultural values that can explain why caregivers report low levels of stress in their workplace, despite breaks being cut and other unfair working conditions.

Of caregivers surveyed, 85.4% answered that they came to the U.S. for work employment and more work opportunities as means to improve their family situation (see Table 2). Serena, a caregiver with family in the Philippines, explains how her job benefits her family in the Philippines, "I have to move here. The salary is better here, right? Compared to ours [in the Philippines] . . . dollars you know. You know like fifty is to one, so you would rather work here. Even your paycheck for one month here is equivalent to one year's worth of paycheck there [in the Philippines]." She went on to explain that her earnings in the US converted to more Philippine pesos than if she were to work the same amount in any occupation in the Philippines. Like a majority of caregivers in our study, she noted that her family depends on her monthly remittance for their daily sustenance. In fact, worrying about her family's ability to meet their basic needs is at the forefront of her mind daily. Serena's transnational familial contextual stress has primacy over the workplace stress she experiences at her work. In this way, Serena's

33. Susan Braedley et al. "We're told," 92.
34. Dutta, "Health Meanings," 645.
35. Jerre M. Tamanal, Kyung E. Park and Cheong H. Kim, "The Relationship of Perceived Stress and Lifestyle Choices among Filipino Adolescents," International Research Journal of Public and Environmental Health 4, no. 10 (2017): 205-212, https://doi.org/10.15739/irjpeh.17.025i.

persistence (or "*tiis*") to deliver financial support regularly drives her work ethic, despite the work conditions as a caregiver. The measures in our survey measured for symptoms of mental health stressors while at work; however, we can argue that oftentimes Filipino caregivers' transnational contexts induce stressors that may supersede workplace factors. Without the proper contextualization of both transnational social relations with workplace conditions at RCFEs, caregivers may interpret workplace stress as secondary to their family obligations.

Utang ng loob, a cultural value, that has been defined as social reciprocity, has been discussed as an obligation to return a favor, support, or service to a person in one's close circle. In the context of the lives of migrant caregivers, one way this can manifest is in regular financial support. Many migrant caregivers interpret their financial support to the Philippines as a tradeoff for not being physically present with their family members. Their remittances, then, are a way of meeting their filial debt while abroad; their reciprocity measured in capital rather than presence. For Filipino caregivers, utang ng loob under this specific sociocultural context is of great import as they negotiate their daily physical and mental health. Their ability to work daily regardless of health conditions does not only describe their work ethic, in fact it is anchored to their ability to provide for their families in the Philippines.

Richelle, a caregiver who left two school-aged children in the Philippines eight years ago now has two young adult children that she hopes to go home to one day. In her kuwentuhan, she recounts her experiences of exploitation and abuse from an employer that isolated her from any social circles outside of her work. Her current employer has been honest and transparent with her which is why she has stayed for eight years. Throughout her ordeal, she has been proud that her daughters have persisted in their education and graduated high school and college. In this way, she feels guilt for missing so much of their lives, but she takes great pride in her ability to fund their education. Still, reuniting with her family is of great import. Richelle stated,

> As long as I'm not with my kids, I should stay strong. I should have a goal, down the road: the ultimate goal is to be reunited with my kids and my mom. So that being established. Just, you know, acceptance of the situation. Stuff at work, I can handle. And I focus towards the goal of being reunited with my kids. So my mental health. I guess that's stable already.

In this quote, Richelle demonstrates *utang ng loob* in identifying that her ultimate goal is to go home and be with her family who have maximized her sacrifice of migration with graduating and finishing up their education. And although she has felt guilty for being away from her family, sending remittances to the Philippines is one way she shows her commitment to them. This necessarily means that Richelle would endure hard work situations and take on multiple jobs to be able to meet

her family's needs. This *utang ng loob*, a debt Richelle feels towards her family, propels her work ethic.

Puri shared these sentiments about *utang ng loob* towards her family. When asked why she works so hard at her job, she responded, "for my family . . . in the Philippines. I still have a house that I am getting fixed, that's why. When the house gets finished, I'm going to lie low." This example of Puri's commitment to reciprocity to her family in the Philippines echoes Richelle's attitude about sending remittances to her family. The income of Filipino caregivers becomes a salient way they stay connected to their families in the Philippines. And as they positively receive news of their families' reciprocity through various forms of stabilizing the family life in the Philippines (e.g., graduation, housing, etc., their work ethic as caregivers are rewarded. In fact, the stressors at the workplace, such as exhaustion or workplace injury, become incidental to their view of their work as caregivers. When asked if Puri had the choice to either stay in the Philippines or move to the U.S., she responded, "Right now I want to stay here because I'm working and then, after that . . . I think I stay in the Philippines." Puri demonstrates that pressures of transnational obligations are attached to how she interprets her persistence as a caregiver.

Filipino caregivers do not see their transnational obligations as a burden. Rather, they see their jobs as caregivers as a privilege to maximize, in the name of their families in the Philippines. Without the sociocultural context of caregivers' Filipino cultural values such as *tiis* and *utang na loob*, caregivers' underreported stress could be interpreted as an acceptance of their exploitative work conditions. However, the qualitative data and our analysis allows us to speculate that when the survival of their family back home is dependent on migrant caregivers' income, the ability of caregivers to identify themselves as "stressed" is compromised. Furthermore, we surmise that to identify themselves as stressed, caregivers would experience an impairment in their ability to care for their elderly patients and therefore disrupt their ability to support their families in the Philippines.

Conclusion

Transnational conditions and the crisis in the eldercare industry are significant sociocultural contexts that inform Filipino caregivers' work ethics and their health outcomes. The transnational ties of Filipino migrants to their families in the Philippines, alongside their cultural values, shape caregivers' attitudes in withstanding labor exploitation and adverse health conditions. The unregulated and underfunded eldercare industry in the US has produced systemic inequities for caregivers, and because the demand for workers is high, this paradox leaves Filipino caregivers in a precarious position. In this paper, we argue that both contexts must be taken into account in assessing caregivers' health and

interpretations of their physical and mental health.

The results for this study clearly suggest that interventions are needed for formal Filipino caregivers in part to educate them of basic workers' rights, such as a right to a break and uninterrupted sleep, covered by state laws in California. Effective health interventions will require a culture-centered approach alongside an awareness of the sociocultural contexts Filipino caregivers occupy when caring for the elderly. More importantly, these interventions must be supported by political collectives and "communities of care" that can not only deliver pertinent information but also create generative spaces for Filipino migrants to build collective resilience and power.

Interventions for education and awareness also need to be disseminated to employers of formal caregivers so that, in turn, the labor standards for formal caregivers can assist them with receiving the best of care. By 2050, the number of elderly persons needing long term care in RCFEs will double to 16.1 million Americans. It will become more acute in 2030, when the first wave of Baby Boomers will turn eighty-five.[36] There is a mounting public health need to better understand the health impacts of the demanding work conditions for formal caregivers (mostly immigrants), to increase their quality of life. And similarly, increase the quality of care for their patients alike. This complementary set of interventions can inform state-wide, long-term solutions for eldercare while ensuring caregivers in this industry have healthy work conditions.[37]

Further, research on mental and physical health of formal Filipino caregivers must craft new measures that are culturally relevant, taking into account not only the complicated conditions of formal caregiving occupations, but also the migrant status and transnational cultural context of workers that may lead them to downplay standard health factors for care workers.

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37. Angela Geraci, Barbara Hutchison, and Ardith Brunt, "California's Newly Reformed Residential Care Facilities for the Elderly (RCFE)," California Journal of Politics and Policy 7 (2015): 1-14, doi: 10.5070/P2CJPP7225650.; California Advocates for Nursing Home Reform.

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