# *Suicidal and Depressive Symptoms in Filipino Home Care Workers in Israel*

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ORIGINAL RESEARCH

# Suicidal and Depressive Symptoms in Filipino Home Care Workers in Israel

**Liat Ayalon**



**Abstract** The study consisted of a cross sectional sample of 178 Filipino home care workers who completed the Paykel Suicide Scale and the Patient Health Questionnaire-9. Respondents also completed questionnaires about exposure to abuse and perceived social support. Overall, 35% of the sample reported exposure to some type of abuse within their home/work environment. For those reporting low levels of satisfaction with care recipient, higher exposure to major lifetime discrimination was associated with higher SIA, whereas for those reporting high levels of satisfaction with care recipient, there was no relationship between exposure to major lifetime discrimination and SIA. Abuse within the home/work environment was the only predictor of depressive symptoms, with greater abuse being associated with higher levels of depressive symptoms. Filipino home care workers in Israel likely are exposed to moderate levels of abuse and discrimination within the home/work environment as well as within society at large. Because live-in home care workers spend the majority of their time within the home/work environment, their relationship with their care recipients have protective qualities that can serve as a buffer against discrimination. Nevertheless, abusive working conditions within their home/work environment have detrimental effects on their mental health.

**Keywords** Mental health · Migration · Ecological model · Racism · Abuse

Several demographic changes have contributed to the shortage of available informal (i.e., unpaid) caregivers to frail older adults. These include the increase in lifespan, decrease in childbirth, nuclearization and fragmantation of the family system, the entrance of women into the work force, and the low status assigned to caregiving in Western society (Ehrenreich and Hochschild 2000). As a result, foreign home care to frail older adults has become a popular alternative in many Western countries (Abu-Habib 1998; Brush and Vasupuram 2006). This caregiving arrangement fulfills the wishes of frail individuals to stay in their home environment (Keysor *et al*. 1999) and is a cheaper alternative relative to institutional care, especially when provided by migrants (Aronson and Neysmith 1996).

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In Israel, foreign workers provide almost all live-in home care, which consists of the provision of personal care to frail older adults and individuals with disability. Currently, there are about 54,000 foreign home care workers in Israel, and according to some estimates, additional 40,000 undocumented workers (Nathan 2008). Live-in foreign home care in Israel is subsidized by the government, which allows only the most impaired individuals to hire a foreign home care worker (Heller 2003). Whereas the government has been attempting to reduce the number of foreign workers in the country, their number has been increasing steadily, because work permits are issued based on demand (Klein-Zeevi 2003).

To date, research has been scarce not only with regard to foreign home care workers who migrate from the developing world to the developed world, but also with regard to the developing world in general. For instance, data regarding suicide is not available for about half of the countries of the world and a third of the world's population (primarily from the developing world), despite the fact that over 70% of the suicides take place in the developing world (Vijayakumar 2004). Similarly, despite sporadic media reports of high levels of suicide among foreign workers in the Middle East (BBC News 1999), there has been no formal study to evaluate suicidal ideation and attempts (SIA) in this population. There has also been limited research on distress in the Philippines and only one study on the burnout experienced by Filipino home care workers who provide care to older adults in Israel (Ayalon 2009a). This scarcity of research, accompanied by sporadic reports that indicate high levels of mental health needs among foreign home care workers (BBC News 1999), reemphasizes the importance of conducting research to further evaluate the mental health needs of individuals from the developing world, especially as they interact with the developed world.

## Potential risk factors

Ample research has demonstrated high levels of exposure to societal discrimination and racism among ethnic minorities and new immigrants in a variety of host cultures (Asakura *et al*. 2008; Ellis *et al*. 2008; Williams *et al*. 1997; Yip *et al*. 2008). The negative consequences of lower integration in society and exposure to racism and discrimination are well recognized, with research demonstrating that higher levels of racism and discrimination are associated with higher levels of depression, posttraumatic stress disorder, and even SIA (Aspinall 2002; Butts 2002; Mullen and Smyth 2004; Ryan *et al*. 2006; Stack 1981; Yip *et al*. 2008).

Less attention has been given to societal discrimination and racism experienced by foreign home care workers. Foreign home care workers often are more educated than the average person in their home country. Further, they receive salaries that are higher than the salary they would have received in their home country. Nonetheless, their status in the host country is low because they take positions that are devalued by the citizens of the host country (Raijman *et al*. 2003). Israel, as a Jewish state, makes every attempt to limit the stay of foreign workers in the country and to prevent them from becoming full citizens (Borowski and Yanay 1997). Furthermore, in contrast to other ethnic minorities in the country (e.g., Arabs, Druz) or new immigrants (e.g., Russian Jews), foreign workers in Israel are considered as temporary workforce and are expected to leave after several years or when their care recipient dies (Heller 2003). A good example of the status assigned to these workers in Israel would be the term used to describe them (foreign workers), in contrast to the more politically correct term (migrant workers), which is not widely used in the country. Hence, it is expected that these workers are exposed to high levels of societal racism and discrimination.

Given the nature of their work, which is performed behind closed doors, within the home/work environment, it is likely that these workers also are exposed to high levels of abuse within their home/work environment. Past research has portrayed home care workers as 'invisible caregivers', whose work is acknowledged only when problems arise (Gilenn 1992). The intimate nature of this round the clock work within the private realm tends to blur the boundaries between private and professional (Lan 2003; Martin-Matthews 2007) and increases the potential for abuse (Ayalon 2009a; Ben Israel 2007). Qualitative research has shown that even when the job description of the home care worker is well defined, the worker is eventually expected to perform additional tasks for longer hours than initially agreed upon at no extra pay (Aronson and Neysmith 1996). These findings were further reinforced by a recent study conducted in Israel that found that almost 50% of the 245 Filipino home care workers interviewed, reported at least some abuse within their home/work, such as being asked to do more than their job requirements at no extra pay or exposure to verbal abuse (Ayalon 2009a). As one would expect, working conditions were directly related to workers' burden (Ayalon 2009a) as well as health and well-being (Denton *et al*. 2002).

Furthermore, given current regulations that allow only the most impaired older adults in Israel to be eligible for a foreign home care worker, one would expect the provision of round the clock care to frail individuals to be a highly taxing job; in particular, caring for older adults with cognitive and physical problems has been associated with multiple negative consequences, including increased morbidity and mortality (Schulz and Beach 1999).

## Potential protective factors

One of the most notable protective factors against psychological distress has been social support. There are two competing theories concerning the relationship between social support and health. The buffering hypothesis suggests that social support protects individuals from experiencing the negative effects of stressors, whereas the main effect hypothesis suggests that social support positively impacts health and mental health unrelated of the stressful effects one may face. In a meta-analysis of the protective role of social support, researchers found that when the number of social relationships are assessed, social support has a main effect, whereas when the perception of available support is assessed, social support serves as a buffer (Cohen and Wills 1985). Because foreign home care workers in Israel are not allowed to bring their family members into the country, one would expect them to report a limited number of available sources of support in Israel, as they are usually confined to the home of the care recipient. Furthermore, because workers are confined to their care recipient's home, degree of satisfaction with the social support available from care recipient may be particularly protective for this population.

## The present study

In this paper, I evaluate SIA and depressive symptoms in a sample of Filipino home care workers (the largest group of foreign home care workers) in Israel. In order to better understand the context in which SIA and depressive symptoms take place, I evaluate the working and living conditions as well as experiences of discrimination within society at large as they relate to SIA and depressive symptoms. In particular, I focus on abuse experiences and working conditions within the home/work environment (e.g., exposure to aggressive or sexual behaviors, providing care to a person with Alzheimer's disease) as well

as exposure to discrimination and racism within the larger context of life in Israel (e.g., both exposure to everyday discrimination and to major lifetime discrimination). As protective mechanisms, I evaluate the potential role of social support both within the home and outside the home as main effects and as moderators of the relationship between the various risk factors and SIA and depressive symptoms.

I expect risk factors (e.g., abuse within home/work environment, major life discrimination) to have a greater effect on Filipino home care workers' SIA and depressive symptoms in those Filipino home care workers who report lower levels of satisfaction with their social relationship. I further expect those Filipino home care workers who enjoy a larger social network and greater satisfaction with their relationship with care recipient to report lower SIA and depressive symptoms.

## Methods

### Procedure

This study was based on prior qualitative research conducted with Filipino home care workers, family members of older adults cared for by the workers, and social workers in charge of this particular caregiving arrangement (Ayalon 2009a; Ayalon *et al*. 2008). Following this prior research, I conducted an additional focus group with 12 prominent members of the Filipino community in Israel (all work as Filipino home care workers). These individuals were asked to complete a draft version of the questionnaire and to provide feedback on its applicability and readability. The questionnaire was subsequently revised based on this feedback. Several members who participated in this focus group had agreed to assist in data collection and received a short training prior to embarking on their data collection efforts. These Filipino home care workers used snowballing techniques to collect the data by capitalizing on their role as prominent members of the Filipino community in Israel. Questionnaires were administered in social gatherings of the Filipino community and in churches attended by members of the community. All participants gave an informed consent prior to participating in the study. Participation was voluntary and participants were not compensated for it. This study was approved by the review board of Bar Ilan University.

### Outcome measure

*Suicidal ideation* The Paykel Suicide Scale contains five items that evaluate suicidal ideation with increasing levels of intent, ranging from passive (e.g., wish you were dead) to active suicidal ideation (e.g., having a concrete plan) or attempts (Paykel *et al*. 1974). The measure has been used in several epidemiological studies and has shown good concurrent validity (Skoog *et al*. 1996). In the present study, participants were asked about their SIA since their arrival to Israel, using a yes/no response format as had been previously used in past research (Bartels *et al*. 2002). In the present study, the measure is used as a scale, with higher scores representing greater SIA (range: 0 to 5). Chronbach's alpha in the present study is .66.

*Depressive symptoms* The Patient Health Questionnaire (PHQ-9) ranks each of the nine DSM-IV criteria on a scale from 0='not at all' to 3='nearly every day' over the past 2 weeks. Major depression is indicated if either item one or two (i.e., anhedonia and depression) are scored 2 or 3 and a total of at least five items are scored as 2 or 3. The

measure has been widely validated for use in primary care (Spitzer *et al*. 1999). Chronbach's alpha in the present study is 87.

## Covariates

Age, gender, marital status, years of education, and years in the country were gathered based on self-report.

## Independent risk factors

*Exposure to abuse within the home/work environment* Participants were asked about their experiences within the home/work environment since their arrival to Israel. Questions from a scale of sexual harassment (Gettman and Gelfand 2007) were added to an existing questionnaire of abuse within the home/work environment specifically developed for use with Filipino home care workers (Ayalon 2009a). The final measure contained 17 items that evaluated a variety of experiences of abuse within the home/work environment. Example questions are: "not receiving the food you need and like; been told offensive stories or jokes." Participants were asked to indicate whether an event has ever happened in their current position as home care workers in Israel. Scale ranges from 0 to 17, with a higher score representing exposure to more types of abuse. Chronbach's alpha in the present study is .72.

*Exposure to everyday discrimination* This measure is a 5-item scale that taps into the hassles associated with perceived everyday discrimination. It represents a measure of chronic stress. In the present study, participants were asked about their everyday life in Israeli society at large. For instance, "people act as if they are afraid of you; people act as if they think you are not smart." Each item is rated on a scale of 1 = never to 4 = always. Measure ranges from 5 to 20, with a higher score indicating greater exposure. The measure has been used in several large-scale epidemiological studies in the past, including the Health and Retirement Study (http://hrsonline.isr.umich.edu/). Chronbach's alpha in the present study is .70

*Major experiences of lifetime discrimination* This is a 6-item yes (1)/no (0) scale assessing major experiences of discrimination (Williams *et al*. 1997). In the present study, participants were specifically asked about experiences since their arrival to Israel. For instance, "have you ever been unfairly denied a bank loan? Have you ever been unfairly stopped, searched, physically threatened or abused by the police?" This measure has been used in epidemiological studies, including the Health and Retirement Study (http://hrsonline.isr.umich.edu/). The scale ranges from 0 to 6, with a higher score representing greater exposure. Chronbach's alpha in the present study .59.

## Protective variables

*Social contacts* The number of monthly contacts with friends or relatives in Israel and the number of friends or relatives one feels close to in Israel were rated on a scale of 0='none' to 5='nine or more'. A composite summary score of the two items was used to assess overall number of social contacts. Range is from 0 to 10.

*Satisfaction with social support* Overall satisfaction with social support available from friends or family in Israel was rated on a scale of 0 = not at all to 3 = very satisfied.

*Satisfaction with the relationship with care recipient* The Burns Relationship Satisfaction Scale is a seven-item self-report scale that assesses satisfaction with various areas of the relationship, such as communication, intimacy, satisfaction with roles in the relationship, and overall satisfaction (Burns and Sayers 1988). In the present study, participants were specifically instructed to refer to their relationship with their care recipient and to rate each of the items on a scale of 0 = fair to 3 = excellent. Range is from 0 to 21. Chronbach's alpha in the present study is .88.

### Statistical analysis

First, descriptive data and correlations between the variables were obtained. Then, attempted suicide rates reported in the present study were compared with the only available national data on attempted suicide in the Philippines (Vizcarra *et al*. 2004). The rate of major depression, as classified by the PHQ-9 was also compared to available data (Chiu 2004). Next, hierarchical regression analyses, with SIA and depressive symptoms as the outcome variables were conducted. For the hierarchical regression analyses, only variables significant at $p<.2$ (Hosmer and Lemeshow 2000) were maintained for further analysis of risk and protective factors of SIA. First, all independent risk factors significant at $p<.2$ (e.g., exposure to major discrimination) were entered into the model. Next, all protective variables significant at $p<.2$ were entered into the model as main effects (e.g., satisfaction with social support). Interaction effects between each of the potential protective variables and the independent risk factors were also examined, with each interaction effect being evaluated separately. Only significant interactions were maintained in the final model. Age, gender, and education were included in all analyses as covariates.

## Results

Table 1 summarizes the demographic characteristics of the sample. The sample consisted of 178 Filipino home care workers. The majority of the sample was married (56.7%) and female (87.6%). A total of 81% of the sample provided care to either one older adult or an older couple (16%), whereas the remaining provided care to an adult or a child with disability. Mean age of respondents was 37(SD=6.3) and the average number of years of education was 8.3(SD=5.0). The average length of stay in Israel was 5.5 (SD=2.4). The majority of the sample provided care to a person with dementia (61.8%). The average number of abuse experiences within the home/work environment was 1.2 (SD=1.6), mean exposure to everyday discrimination was 8.5 (SD=3.2) and mean exposure to major discrimination was .44 (SD=.94).

Overall, 24% of the sample reported that since their arrival in Israel, they had felt that life was not worth living, 7.9% reported that they had wished they were dead, 7.3% reported that they had thought of taking their life off, 14.6% stated that they had reached the point that they had seriously considered taking off their life or made some plans as to how they would go about doing so, and 4.5% indicated that they had made an attempt to take off their life. Relative to national data on lifetime prevalence of attempted suicide in the Philippines (1.4%) (Vizcarra *et al*. 2004), the present sample reported significantly more suicide attempts (4.5%; chi-square=8.57, $p$=.003) . No other relevant data were available in the international literature for comparative purposes. Average score on the depressive symptoms measure was 4.06(SD=

**Table 1** Demographic and clinical characteristics of the sample and correlates with SIA and depressive symptoms ($n$=178)

| | Descriptive Data | Correlation with SIA | | Correlation with Depressive Symptoms | |
|---|---|---|---|---|---|
| | Mean (SD)/N(%) | r | p | r | p |
| Covariates | | | | | |
| Age (24–54) | 37.3(6.3) | −.02 | .75 | .01 | .88 |
| Gender | | −.05 | .46 | .04 | .57 |
| Female | 156(87.6%) | | | | |
| Marital status | | −.03 | .65 | .02 | .75 |
| Married | 101(56.7%) | | | | |
| Education (0–19.5) | 8.3(5.0) | .17 | .18 | .14 | .13 |
| Years in the country (.6–13.1) | 4.4(2.42) | −.08 | .27 | −.10 | .19 |
| Independent Risk Factors | | | | | |
| Hours providing care per day (3–24) | 20.2(6.1) | .05 | .51 | −.20 | .01 |
| Caring for an older adult with dementia | 110(61.8%) | .12 | .10 | .07 | .34 |
| Exposure to abuse within the Home/Work Environment (0–17) | 1.21(1.63) | .01 | .85 | .20 | .009 |
| Exposure to everyday discrimination (5–20) | 8.59(3.27) | .18 | .02 | .18 | .01 |
| Exposure to major lifetime discrimination (0–6) | .44(.94) | .26 | <.001 | .06 | .39 |
| Protective Factors | | | | | |
| Social contacts (0–10) | 4.9(2.38) | −.20 | .006 | .12 | .12 |
| Overall satisfaction with social support (0–3) | 1.72(1.12) | −.15 | .03 | .22 | .005 |
| Satisfaction with the relationship with care recipient (0–21) | 12.5(5.30) | .12 | .10 | −.05 | .47 |

4.61). A total of 3.4% were classified as depressed. This rate falls within the range reported in the Asian pacific region (1.3%–5.5%) (Chiu 2004). The correlation between SIA and depressive symptoms was non-significant ($r$=.10, $p$=.19).

Overall, 35% of the sample reported exposure to some type of abuse within their home/work environment. The most common types of abuse were 'been asked to do more than one's job requirement' (35%), 'been shouted/sworn at' (30%), 'been told offensive stories or jokes' (20%). The most frequent exposure to everyday discrimination was 'people think as if you are not smart' (Mean=2.05, SD=1.00). The most common major lifetime discrimination was 'been unfairly stopped, searched, physically abused, or threatened by the police,' as acknowledged by 10% of the sample.

With regard to SIA, the following risk factors met the significance level of .2 and were evaluated in subsequent models: caring for an older adult with dementia, exposure to everyday discrimination, exposure to major discrimination. The following protective factors med the significance level of .2 and were included in subsequent model: overall satisfaction with social support, social contacts, and satisfaction with the relationships with care recipient. See Table 1.

In the first step of the multivariate regression, all potential risk factors were entered into the model. Exposure to every day discrimination and major life discrimination were significant predictors of SIA. This model explained 13% of the variance. In the next step, all protective variables were entered into the model. This model explained 19%, with

exposure to everyday discrimination and major life time discrimination being significant predictors of SIA. Next, the interaction between risk and protective factors were examined. Two significant interactions emerged (e.g., satisfaction with care recipient* major discrimination, overall satisfaction* everyday discrimination), but only the former remained significant in the final model. The only significant predictors were the interaction between satisfaction with care recipient and major discrimination and exposure to major discrimination as a main effect. This final model explained 23% of the variance. See Table 2.

Figure 1 demonstrates that for low levels of satisfaction with care recipient (0–7), there is a relationship between exposure to major life discrimination and SIA, so that the higher the exposure to major life discrimination is, the higher the SIA are, whereas for high levels of satisfaction with care recipient (8–21), there is no relationship between exposure to major life discrimination and SIA.

**Table 2** Hierarchical regression analysis to examine risk and protective factors of SIA ($n$=178)

| | B | SE | p |
|---|---|---|---|
| Step I- Risk Factors (R^2=.13, $p$=.001) | | | |
| Age | −.004 | .01 | .74 |
| Gender | −.37 | .27 | .16 |
| Level of education | .02 | .01 | .14 |
| Providing care to a person with dementia | .19 | .18 | .30 |
| Exposure to everyday discrimination | .05 | .02 | .03 |
| Exposure to major life discrimination | .27 | .08 | .002 |
| Step II-Protective Factors (R^2=.19, $p$=.001) | | | |
| Age | −.007 | .01 | .62 |
| Gender | −.24 | .27 | .38 |
| Level of education | .02 | .01 | .20 |
| Providing care to a person with dementia | .23 | .18 | .20 |
| Exposure to everyday discrimination | .05 | .02 | .04 |
| Exposure to major life discrimination | .27 | .08 | .001 |
| Satisfaction with the relationship with care recipient | .01 | .01 | .28 |
| Overall satisfaction with social support | −.10 | .08 | .21 |
| Number of social contacts | −.04 | .04 | .26 |
| Step III- Moderators (R^2=.23, $p$<.001) | | | |
| Age | −.004 | .01 | .77 |
| Gender | −.29 | .27 | .27 |
| Level of education | .01 | .01 | .37 |
| Providing care to a person with dementia | .24 | .17 | .17 |
| Exposure to everyday discrimination | .04 | .02 | .10 |
| Exposure to major life discrimination | .27 | .08 | .001 |
| Satisfaction with the relationship with care recipient | .01 | .01 | .32 |
| Overall satisfaction with social support | −.09 | .08 | .26 |
| Number of social contacts | −.06 | .04 | .14 |
| Satisfaction with relationship with care recipient*major discrimination | −.04 | .01 | .003 |

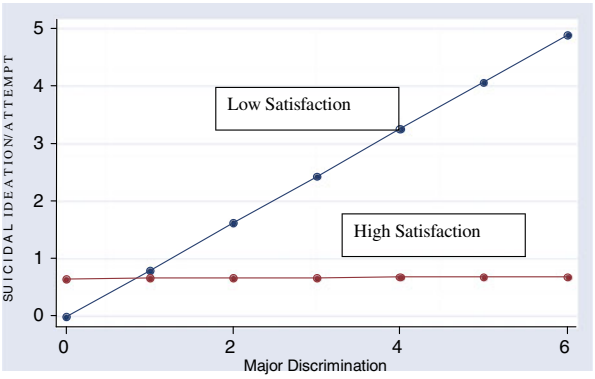


**Fig. 1** The relationship between suicidal ideation and attempts and exposure to major discrimination as a function of satisfaction with the relationship with care recipient

As for depressive symptoms, the following risk factors were significant at $p<.2$ and, thus, included in multivariate model: hours of care per day, exposure to abuse within the home/work environment, exposure to everyday discrimination. The following protective factors had a $p<.2$ in bivariate analysis and, thus, included in multivariate analyses: number of social contacts and overall satisfaction with social support. In the first step, only risk factors were entered into the model. See Table 1.

In the first step of the hierarchical regression analysis, the only significant predictor was exposure to abuse within the home/work environment. This model explained 10% of the variance. Next, protective variables were entered into the model. Once again, the only significant predictor was exposure to abuse within the home/work environment. None of the protective variables examined were significant. In addition, there were no significant interaction effects between risk and protective factors. See Table 3.

**Table 3** Hierarchical regression analysis to examine risk and protective factors of depressive symptoms ($n=178$)

| | B | SE | p |
|---|---|---|---|
| Step I- Risk Factors (R^2=.10, $p=.04$) | | | |
| Age | .003 | .60 | .95 |
| Gender | .58 | 1.52 | .70 |
| Level of education | .04 | .07 | .54 |
| Exposure to abuse within the Home/Work Environment | .39 | .15 | .01 |
| Exposure to everyday discrimination | .21 | .14 | .12 |
| Step II-Protective Factors (R^2=.12, $p=.05$) | | | |
| Age | .001 | .06 | .99 |
| Gender | .36 | 1.58 | .81 |
| Level of education | .06 | .08 | .45 |
| Exposure to abuse within the Home/Work Environment | .39 | .16 | .01 |
| Exposure to everyday discrimination | .22 | .14 | .12 |
| Overall satisfaction with social support | .69 | .51 | .18 |
| Number of social contacts | −.03 | .22 | .88 |

## Discussion

Foreign home care to frail individuals has become a popular alternative to informal care in the developing world (Ehrenreich and Hochschild 2000). Nonetheless, the literature on this popular caregiving arrangement is scarce. Thus, there are only anecdotal media reports of high levels of suicide in this group of vulnerable foreign workers (BBC News 1999), but no empirical research has been conducted. This is the first study to empirically evaluate SIA and depressive symptoms in foreign home care workers in Israel.

Overall, 4.5% of the sample reported that since their arrival to Israel, they had made an attempt to take their lives. In addition, 3.4% of the sample was classified as depressed, using the PHQ-9 criteria. It is difficult to evaluate these results in context because of the scarcity of mental health research not only on foreign home care workers who migrate from the developing world to the developed world, but also on the developing world in general (Vijayakumar 2004). The one study to have evaluated suicide attempts in the Philippines reported a significantly lower prevalence rate (Vizcarra *et al*. 2004) relative to the present study, suggesting that this group of Filipino home care workers is particularly vulnerable. On the other hand, the prevalence of depression was in accordance with past research in East Asian countries (Chiu 2004).

A lack of correlation between depressive symptoms and SIA found in the present study is puzzling. In reviewing these findings, it is important to take into consideration the limitations of Western measurement tools for the evaluation of psychopathology in individuals from the developing world. It also is important to note that past research has shown that individuals from Asian cultures tend to report lower levels of life satisfaction, less pleasant emotions, and greater negative emotions relative to individuals from Western cultures (Diener *et al*. 1995; Kitayama *et al*. 2000). Further research is much needed in order to better appreciate the present findings in context.

One of the most notable findings of the present study concerns the working conditions of foreign home care workers. Results suggest that Filipino home care workers in Israel likely are exposed to moderate levels of abuse and discrimination within the home/work environment as well as within society at large. Over 70% of the sample acknowledged being exposed to at least some form of everyday discrimination, with the most frequently mentioned item being: "been treated with less courtesy than others" and "been treated as if you are not smart." Moreover, 26% of the sample reported being exposed to at least one type of major lifetime discrimination; "been unfairly searched by the police" was the most frequent type of lifetime discrimination mentioned.

Over 50% of the sample reported being exposed to at least one type of home/work related abuse and 37% reported being exposed to at least two, with the most frequent types of abuse were: "been asked to do more than one's job requirement" and "been shouted or sworn at." Even though many reported exposure to abuse experiences within the home/work environment, the more severe experiences of sexual or physical nature were hardly acknowledged in the present study. Nevertheless, the fact that these experiences were not acknowledged does not necessarily mean that workers did not experience them. Past research has shown that although social workers in charge of this caregiving arrangement and family members of older adults cared by Filipino home care workers openly acknowledge both sexual and physical abuse of Filipino home care workers, the workers themselves, hardly ever mention abuse of sexual or physical nature (Ayalon 2009a). Hence, the low rates reported in this study could be partially attributed to the stigma associated with being sexually harassed. Given the fact that Filipino home care workers come from a collectivistic society, they may refrain from disclosing abuse in order not to shame not only

themselves, but also their families. Fear of losing their job and/or their permit to work in the country may also explain the low levels of reported sexual and physical abuse found in this study (Ayalon 2009a).

The fact that clients' dementia status was not associated with home care workers' SIA or depressive symptoms may be explained by past research that found that people of Asian descent tend to view dementia as a normal part of life (Hinton and Levkoff 1999). It may also be explained by past research that showed that Filipino home care workers are particularly equipped to treat behavioral problems of patients with dementia (Ayalon 2009b).

The theoretical model evaluated in the present study was only partially supported. Neither abuse within the work/home environment nor working conditions were associated with SIA. Exposure to major discrimination of acute and unpredictable nature was the only significant correlate of SIA. Yet, the impact of major discrimination was buffered by the protective effect of the relationship with the care recipient. For those Filipino home care workers who reported satisfactory relationship with their care recipient, even exposure to major discrimination was not associated with increased SIA. Yet, for those Filipino home care workers who reported poor interpersonal relationship with their care recipient, the exposure to major discrimination was associated with increased levels of SIA. Unexpectedly, neither satisfaction with the relationship with friends and relatives nor social contacts with friends and relatives had a similar protective role, suggesting that the intimate relationship with the care recipient is of utmost importance. Given the fact that the average number of reported caregiving hours per day was 20 in the present sample, it makes sense that the relationship with the care recipient has a stronger protective effect than all other social relationships.

As for depressive symptoms, the only significant predictor was exposure to abuse within the home/work environment. Consistent with past research (Ayalon 2009a), those respondents who reported greater levels of abuse within their home/work environment were more likely to report depressive symptoms. None of the other risk or protective factors was significantly correlated with depressive symptoms. Further research is recommended in order to identify protective factors in this population.

The present study does not go without limitations. As with any study conducted with a minority culture, there is always the risk of cultural bias. This was partially addressed by reliance on past qualitative research (Ayalon 2009a) and by conducting a focus group to preliminary review and modify the questionnaire. Another limitation is the use of snowballing techniques rather than a random sample. However, given the fact that about 50% of the workers are undocumented, a random sample likely would have resulted in an under sample of undocumented workers. An additional limitation is the fact that the scales used to assess social support with friends and relatives were less comprehensive than the scale used to assess social relationships with care recipient. In addition, the scale of major lifetime discrimination had a low reliability in the present study. However, the low reliability of this scale could be attributed to its focus on stressors of acute nature, which do not necessarily co-occur. Thus, had the sample size been larger, examining each acute stressor separately might have been more informative.

Nonetheless, this study has several strengths that outweigh its weakness. Even though foreign home care to older adults has become a popular caregiving alternative in recent years, there is only limited research on the topic. Furthermore, as already mentioned, SIA and depressive symptoms have hardly been studied not only among Filipino home care workers in Israel, but also among Filipinos in the Philippines. Conducting such a study to evaluate the mental health needs and working conditions of Filipino home care workers is important not only theoretically, but also morally as it allows them to become 'visible.'

Another advantage of this study is its comprehensive focus on both risk and protective factors within the home/work environment as well as within society at large. Finally, the fact that this study attempts to identify within group differences, rather than between group differences is an additional advantage of the study.

To sum, results suggest that Filipino home care workers in Israel are exposed to moderate levels of abuse and discrimination within the home/work environment as well as within society at large. Moreover, the present sample reported high levels of suicide attempts relative to national statistics in the Philippines. The study further shows that the quality of the relationship of the home care worker with the care recipient serves as a major source of protection against major lifetime discrimination. Finally, depressive symptoms were associated with abuse within the work/home environment, suggesting that the working conditions of foreign home care workers should be more strictly supervised.

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