

A STRESS COPING MODEL FOR OLDER KOREANS :
EFFECTS OF SOCIAL SUPPORT AND RELIGIOSITY ON DEPRESSION

by

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(Under the Direction of NANCY P. KROPF)

ABSTRACT

Social work professionals have been concerned about the mental health and psychological well-being of older persons, as well as elders' need for and utilization of mental health service. However, little research on the health and behavior of minority older adults has been conducted. Furthermore, the mental health knowledge about older Koreans and older Korean Americans is almost non-existing in empirical research of social work field. Therefore, there is a need for a greater integration of racial and ethnic perspectives and cross-cultural consideration in research on aging and mental health.

The present study has a unique aim to contribute to cross-cultural research and practice on aging and mental health by comparing two groups of older Koreans; those living in Korea and those living in the United States. The purposes of this study were 1) to examine Korean older adults' unique physical and mental health status; 2) to address Korean religious and cultural issues in providing comprehensive models of care; 3) to suggest the availability and use of medical, social, and economic resources by Korean older adults.

The results of the present study supported existing substantial research examined the relationship between older adults' depressive symptoms and their poor health and functional

disabilities. This study's results also verified research that demonstrated positive mental health benefits accruing from religious practice for older Korean-American immigrants, and the importance of social support was also confirmed for both samples. This study results demonstrate the need for more attention by researchers to the particular mental health problems of both older Koreans. This study provides a rationale for developing empirical-based social work interventions that can be used with Korean older adults living in Korea and in the United States.

INDEX WORDS: Stress-coping model, Social support, Religiosity, Depression, Older Koreans, Older Korean-Americans, Social Work

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DEDICATION

To my loving grandmother, Heung-Pyo Hong

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CHAPTER 1

SOCIAL PROBLEM ANALYSIS

The Aging Population in the USA

The aging of the population is one of the most profound and far-reaching changes affecting contemporary society. The number and proportion of older people in the population has grown dramatically, raising concerns about the well-being of older people and their families and the economic and health of society as a whole. For mental health professionals, these demographic and social changes mean that an increasing number of older people are seeking more and better psychosocial services and programs (e.g., Binstock, 1998).

The U.S. population is getting older, with 35 million people age 65 and over in the United States in 2000 (Hetzel & Smith, 2001). This number represents a 12.0% increase since 1990, when there were 31.2 million people in the same age bracket (Hobbs, 1996). Although the number of people 65 years and over increased between 1990 and 2000, the proportion in the general of the total population dropped from 12.6 % in 1990 to 12.4 % in 2000 (Hetzel & Smith, 2001). However, the older population is expected to grow in the future, with the most rapid increase expected to occur between the years 2011 and 2030, when the “baby boom” generation reaches age 65 (Wykle & Kaskel, 1991).

The U.S. aging population also represents racial and ethnic diversity. While persons of Hispanic origin represented approximately 4 % of the older population, 6 % of the Asian Americans/Pacific Islanders was 65 years of age and over (Wykle & Kaskel, 1991). According to the U.S. Census report (1996), Asian and Pacific Islanders was the fastest growing racial group

age 65 and over in the U.S. in the last 20 years. This trend is predicted to continue for the next 10 years, mostly due to immigration. In fact, they increased in size by 11.5 % from 1980 to 1990 and were expected to form 7.4 % of the older population by the year 2000 (U.S. Census Bureau, 1996). As this largely young immigrant population of Asian Americans ages over the next 50 years, the number of older Asian Americans over 65 is expected to increase by 1000 % (Tanasiri, Wallace, & Shibata, 1995).

Korean Americans are one of the fastest growing ethnic population in the United States. The 2000 Census estimated 1,076,872 Korean Americans, the 5th largest group among Asian and Pacific Islander following Chinese, Indian, Filipino, and Vietnamese population (US Bureau of the Census, 2000). Although Korean older adults over 65 years in the USA are estimated to be less than 5%, continued immigration rate and family reunification are likely to increase the number of older Korean Americans in the USA.

The rapidly changing demographic landscape in the US has significant implications. More attention must be paid to aging minorities in the United States. Particularly, the dramatic increase in this population will be demanding of better empirical understanding of the health status of elderly immigrants. More research needs to examine the impact of ethnicity on the aging process. Both public and private organizations should use race and ethnic demographic information to find groups that may be in need of special education, physical and mental health, and other fundamental social services.

Aging and Mental Health

The psychological well-being and mental health of older adults have become major interest areas in gerontological research and literature. However, less is known about the mental health of older adults than about their physical health (Fillenbaum, 1988; Harel & Biegel, 1995).

Evidence indicates that as people get older, they may experience a range of mental disorders. (e.g., Zarit and Zarit, 1998). The most common functional disorders in late life are depression, anxiety, adjustment disorders, alcoholism, schizophrenia, paranoid disorders, and personality disorders (Blazer, 2002; Zarit & Zarit, 1998). It has been estimated that 15 % to 25 % of older adults experience mental health problems (American Psychological Association (APA), 2002; Zarit & Zarit, 1998). According to the Surgeon General's Report, "Older Adults and Mental Health," 20% of those age 55 and over in the U.S. suffers from a mental illness or disorder (U.S. Department of Health & Human Services (DHHS), 1999). Up to 88% of nursing home residents exhibit mental and behavioral problems, with depression and dementia being the most common problems (APA, 2002).

Depression is the most commonly found mental disorder among older adults (Blazer, 2002). Hence, depression has often been regarded as a defining characteristic of later life. Although the rates of major depressive disorders (MDD) in older adults are relatively low when compared to younger adults, prevalence rates of depressive symptoms in community dwelling older adults average 20% to 30% (Blazer, Burchett, Service, & George, 1991). These rates underestimate the prevalence in minority aged, older women, and those with chronic medical conditions (Badger & Donker, 2000). Depression among the elderly may be affected by multiple factors, including loss of influential position, poor physical health, functional impairment, fears of impending death, and lack of social and family support (Blazer et al., 1991).

Despite the dramatic growth of the older population, the mental health field has been slow to respond with adequate numbers of trained professionals who have specialized gerontological training (Blazer, 2002; Zarit & Zarit, 1998). Older people are often regarded as uninteresting and untreatable, and they have been under-served by mental health professionals.

The increase in knowledge about the relationship between aging and mental health suggests that many of the common problems of later life respond to treatment and that mental health professionals can significantly improve the functioning of older people and their families.

Aging and Ethnicity

Since the number of older adults in various racial ethnic groups in the US is increasing, a greater understanding is needed about their aging experiences. Especially, the Asian American group is uniquely divided. Asian American and Pacific Islander older adults consist of two main groups (Asian Americans and Americans of Pacific Islands) and are further subdivided into at least 30 other distinct ethnic subsets (Hooyman & Kiyak, 1998). Adding to this diversity is the timing of immigration. Since immigration quotas based on race and nationality were repealed in 1965, immigration populations have been growing rapidly (Hooyman & Kiyak, 1998). There is considerable variability within the foreign-born Asian American and Pacific Islander population. Among new immigrants (Koreans, Thais) or refugees (Vietnamese, Laotians, and Cambodians), the percentage of foreign-born persons is even higher (Tanasiri, Wallace, & Shibata, 1995; Yee, Kim, Liu, & Wong, 1993).

In addition, there has been an increase in the direct immigration of older Asian Americans who are the parents and grandparents of young immigrants from China, Korea, Philippines, and Vietnam. These four countries are the source of 30% of all older immigrants to the United States (Tanasiri et al., 1995). However, changes in immigration law as part of the 1996 welfare reform laws have posed new barriers. Legal aliens and older immigrants are now restricted from getting government assistance for five years (Binstock, 1999). Furthermore, while many older Asian Americans qualify for public financial and health support such as Supplemental Security Income, Medicare and Medicaid, they do not apply (Binstock, 1999).

Their reluctance to seek non-familial assistance is also influenced by cultural and linguistic traditions emphasizing hierarchical relationships, personal social status, and self-restraint (Wykle & Ford, 1999).

Although there is a widely held perception that Asian Americans are a “successful” minority, there is a bifurcation in income and educational attainment among the older population. Asian-Americans who have recently immigrated tend to have incomes below the poverty level (Baugher & Lamison-White, 1996). Approximately 14 % of Asian American and Pacific Islander older adults live below the poverty line (Nishi, 1995; Young & Gu, 1995). The poverty rate may be even higher than that reflected in official statistics due to cultural and structural barriers. Many Asian American older adults still speak only their native language and 30 % of this population live in households where no adults speak English. This reduces their ability to successfully obtain many social services, and they often remain isolated within their native communities (i.e., Chinatown, Korea-town) and segregated from society at large (Tanjasi et al., 1995).

In addition to social economic status among Asian American older adults, their physical and mental health status becomes an issue in aging studies. Recently, a high prevalence of depressive symptoms among Asian immigrant elderly has been revealed (Casado & Leung, 2001; Shibusawa & Mui, 2001; Stokes, Thompson, Murphy, and Gallagher-Thompson, 2001). Those important findings underscore the urgency for more research on the mental health of Asian immigrant elderly. Despite the increasing number and high prevalence of mental health problems among this group of immigrants, research on mental health problems of elderly immigrants has been largely neglected (Casado & Leung, 2001). Because it is likely that large numbers of Asian Americans will continue to grow in the United States, a major challenge for

researchers and service providers is to take account of this fact and recognize the variety of cultural values that exist within these different groups of immigrants (Braun & Browne, 1998).

Social workers face the challenge of successfully providing adequate care to the rapidly increasing numbers of racially and ethnically diverse older adults. Social and cultural differences range from food preparation to religious practices, accompanied by these minorities varying adherence to prevailing American norms (Kim, Kliefer, & Kropf, 2001). In addition, differing attitudes and beliefs about mental illness and the role of social workers all may contribute to the nature of psychosocial therapeutic methods, help-seeking behaviors, and the establishment of meaningful bonds between these elders and social work professionals.

The Aging Population in Korea

Demographic Changes

The aging of the population has emerged as a critical social issue in Korea. The rapid process of demographic transition has brought about an increase in both the absolute number and proportion of the elderly in Korea. Korean older populations aged 60 and over increased from 1.5 million in 1960 to 3.3 million in 1990, and are projected to increase to 9.9 million by the year 2020 (Kim, Liang, Rhee, & Kim, 1996). As an inevitable consequence of declining fertility and mortality rate, the proportion of the aging population in Korea shows an apparent increasing trend, from 5.2% in 1966 to 7.7 % in 1990, and is expected to reach 19.5% in 2020 (Kim, Liang, Rhee, & Kim, 1996).

The aging population age 65 and over in Korea will multiply nearly three times in number and more than two times in proportion by the year 2020, and the aging problem will definitely become the core of social problems in the 21st century. Dramatic changes of aging and problems of the aging population in Korea can be determined through a series of demographic

indicators such as: 1) rapid growth of the aging population, 2) extension of life expectancy of older adults, and 3) change of age structure and related aging indices.

In addition to demographic indices already mentioned such as numerical growth, growth rate, and proportion of the aging population as an index of aging, various dependency ratio and aging index are obviously the more important indicators of aging directly relating to the practical problems for older population in Korea. The elderly dependency ratio, or the number of persons 65 and over per 100 persons ages 15 to 64, which denoted the burden of dependency, showed that the ratio is multiplying very fast and is expected to reach 9.4 in 2000 and 17.5 in 2020. This projection displays that a rapid aging process is taking place in Korea.

Socio-Economic Characteristics

There are several socio-demographic changes which Korean older adults have experienced during the past few decades of industrialization and westernization. First, the gender ratio has constantly been less than 100 and is much lower among the older adults because of an echo effect of the Korean War (1950-1953) (Kim et al., 1996). Because a substantial proportion of males born before 1930 were at risk of being killed in battle, the disproportionate number of deaths among these males might have left a high proportion of females widowed, or women who never married. Thus, the proportion of currently married elderly is much lower for females than for males (Kim et al., 1996). It is also noticeable that a considerable proportion of female elderly are more likely to live in a one-person households in Korea.

Second, there are significant changes in the living arrangement of the older population. Two major features of the changes during the past few decades are the increased proportion of those living alone or living with a spouse only and the subsequent decreased proportion of those living with extended family members (Kim & Choe, 1992).

In spite of changing trend reflecting the traditional norms and the generally accepted consensus in the case of Korea, 99.7% of the elderly 65 and over are living in one form of a family or another as of 1993, and only 0.29% of the elderly are residing in social welfare institutions (Choi & Suh, 1995). A noteworthy fact is that about 47% of the elderly are living in a 3-generation family household with their children, mainly with their son's family including grandchildren, which clearly suggests that the elderly persons are living under the auspices of their children (Rhee, Chang, Roh, & Park, 1993). However, the family compositions of households are changing in the direction of 1) rapid decreasing trend of 3-generation family, 2) considerably slow diminishing trend of two-generation family, and 3) rapid annual increase of one-person household and one generation family. In short, the family composition of Korea is in a stage of transformation from a large collectivistic family type to a small individualistic family.

Third, both economic activity and education level should be examined as important characteristics among older Koreans. Economic activity among older Koreans remains quite low due to the retirement system in non-agricultural sectors. The economic participation rate of the elderly as a whole was 28.4% in 1990 and they share noteworthy traits such as 1) male participation rate surpassing those of females, and 2) participation rates in rural sectors (mainly agricultural) (Choi & Suh, 1995). The proportions of older population engaging in occupations requiring higher educational attainment such as professional, technical or administrative, and managerial are relatively very small. In addition, considering that living arrangements of the elderly are closely related to the financial situation of older Koreans, the proportion of the elderly receiving financial support from family members (mainly married sons) is around 64%.

The elderly comprising the 60 and older age group were born before 1944 and have grown up in a traditional agrarian society. Therefore, Korean older adults have not had much

opportunity to attend modern educational institutions. The Korean older adults who have never attended school are almost 60%, while only 34% attended at least elementary school, and only 3.6% had higher educational opportunities on a college and university level (Kim et al., 1996). Older Korean women's educational level is far lower than older Korean men's. Almost 67% of the female elderly have never attended school, and the rate of attending college is less than 1% (Choi & Suh, 1995).

Finally, it is also important to consider religion and the value system among older Koreans. Korea is a multi-religious country where 80% of the population has some affiliation with Christianity, Buddhism, Confucianism, Taoism, shamanism and other new and quasi-religions (Kim, 1979; Kim, Jiang, Cui, Lin, Kang, Park, Chung, & Kim, 1993). One of Buddha's fundamental insights is the recognition that everybody suffers from illness, growing old, death, separation from loved ones and unfulfilled desires. In Korea, the emphasis in Confucianism is on emotional control for the sake of cultivating an attitude of reason in hierarchical interpersonal relationships especially toward the elderly. Although all the Asian religions have holistic spiritual aspects, each religion seems to have an emphasis, which ultimately influences mental health: correct behaviors in Confucianism, insight (cognitive) in Buddhism, being natural and cosmological (physical) in Taoism.

Structural and Family Factors

Since 1960, as an inevitable consequence of extensive industrialization and urbanization observable in Korea, the nuclear family type has brought about many problems relating to the breakdown of traditional family systems and support mechanisms for the older parents at home. In Korea, like most Asian countries under the influence of Confucian philosophy, the family tie is closely knit and people live mostly within the arc of their family under the belief that the

family is the priority to the individual members. However, since Western civilization had been introduced, the industrialization, urbanization, and nuclearization of family have caused the breakdown of traditional cultures in Korea and enormous changes have been taking place in every corner of life since the Korean War of 1950.

During those dramatic historical and social changes, the traditional support system for the older adults is in a state of decay, there are many problems related to caring for older adults, which had originally been regarded as a matter of the individual family and solved within the family but are becoming more public as the burden of society. In this context, the so-called ‘quadruple hardships for older Koreans have become the core of public concern. Four factors for older Koreans are 1) economic difficulties, 2) health problems, 3) suffering from loneliness and boredom, and 4) alienation from society (Choi & Suh, 1995). Now the Korean government is fully aware of the greater need to pursue appropriate policies to meet these problems within the framework of economic capability and cultural values.

In spite of that, the Korean society still shares a strong tradition of a close-knit family structure and the elderly live with their children, fostering intergenerational ties. Although the noble traditional virtue of filial piety (children’s duty of care for parents) has weakened due to various reasons, in of Korea, 87.3% of the people still hold the belief that they are responsible for supporting older parents (Kim et al., 1996). Those changes suggest that there will be much possibility that older parents will not be able to anticipate that they will be cared for by their children in older age. In the context of such sweeping social changes, various perspectives on the redefinition of family life, changes in family structure and functions, and the family’s responsibility for the elderly are carefully considered.

Summary

The distinct feature of the government's welfare policy for the elderly in Korea is basically rooted in traditional values and norms, and adds an effective Western social security mechanism to these bases. In order to realize the goals and to improve social welfare for the elderly, the government has been implementing various appropriate measures and adjustments on the level of the elderly themselves, the family, and also on a social and community level.

Current issues related to aging population obviously include such issues as 1) implication of an aging population on socioeconomic development and national policies, 2) the role of older adults, families, and communities in the context of an aging society, and 3) the nature and adequacy of support policies and programs to deal with the problems of older population in future. Korea has been confronted with similar problems, and is calling for proper counter-measures for these anticipated changes and care for older adults.

Social Work Perspectives

Social work professionals have been concerned about the mental health and psychological well-being of older persons, as well as elders' needs for and utilization of mental health services. In addition, there has been a significant amount of research concerning mental health problems of older adults and obstacles and limitations in delivering of mental health services to this segment of the U.S. population (Biegel & Farkas, 1989; Blazer, 2003). In the area of mental health, social work professionals are concerned that older persons do not utilize their fair share of community-based mental health services. Older adults consume fewer mental health care services than would be expected, given their overall proportion in the general population. A better understanding of the mental health care needs of older adults is needed due

to the growing body of evidence about elders' frequency, types, and severity of mental illness (Harel & Biegel, 1995).

Ethnicity serves as an important element in the formulation of social work theory and social work practice principles. Mental health has become an important area of specialization in social work education, and ethnic-sensitive practice is heavily emphasized in the social work education and practice settings (Kao, & Lam, 1997; Kim, 1990). The issues of concern in social work practice with ethnic populations include awareness of ethnic diversity and interethnic group relations (Jenkins, 1988). It is generally assumed that a better understanding of the role of ethnicity in the lives of older adults would enhance the planning and delivery of effective services for older individuals and families. This awareness has brought about an increasing emphasis on the need for ethnic-sensitive practice in social work (Devore & Schlesinger, 1991).

There must be a deep and abiding respect for elders, their family structures, and their cultural aversion to institutional care. It is true that data on older ethnic groups, especially those other than African Americans, are less available (Stanford & Dubois, 1993). However, it is also important to explore the strengths of racial and ethnic group behaviors that contribute to their relatively psychologically intact passage through the life span (e.g., Harada & Kim, 1995; Harel & Biegel, 1995).

As briefly reviewed in this section, research indicates that in addition to objective states of health impairments and functional limitations, knowledge about benefits and services, access to services, and attitudes about service use also play important roles (e.g., Biegel & Farkas, 1989; Binstock, 1998). Evidence has indicated that informal sources of support have not only social and emotional value in assuring the security and well-being of older persons, but also play an important role in reducing the need for, and use of, costly institutional services (Krause, 1990;

1997a; 1998; Potts, 1997). Unfortunately, little research to date examines the ways in which membership in ethnic groups affects the utilization of mental health and social services (Pagett, 1995; Perez, 1996). There is a need for more systematic research to ascertain the mental health and social services needs of ethnic minority elders.

Given the stigma of mental illness and negative perception toward public assistance by these ethnic communities in general and the ethnic elderly in particular, social work practitioners and researchers need strategies for addressing this obstacle to service utilization. Religious, ethnic, and fraternal organizations are important sources of trust, emotional and instrumental support, and attachment to the community by the ethnic elderly. Some research has demonstrated that mental and social service agencies form alliances with ethnic churches and organizations (Choi & Tirrito, 1999; Naparstek, Biegel, & Spiro, 1982). When ethnic religious and lay leaders are sought for their advice on how mental health and social services can be delivered in a community context, barriers to seeking help can be reduced and overcome.

The Need for Research

Compared with African Americans and Hispanics, information about older Asian Americans is extremely limited. Comparatively little research on the health and behavior of Asian American older adults has been conducted (Biegel & Farkas, 1989; Mui 1996). This is due in part to the difficulty of recruitment and collection of data on these relatively small Asian groups (Devore & Schlesinger, 1991). Specifically, older Asian Americans tend to underutilize Medicare and Medicaid, relying instead on non-Western medicine or family or friends to assist them with their health problems (Harada & Kim, 1995). It has been estimated that 33 % of Asian American older adults have never seen a Western doctor, and only about 2 % are in nursing homes (Braun & Browne, 1998; Kim, 1990). The low utilization of traditional health services is

probably due to a combination of their having fewer chronic diseases than persons in the general population, to structural barriers to health care, and to elders' reluctance in using formal Western health services (Harada & Kim, 1995). Korean Americans tend to hold themselves and their families responsible for their problems rather than turn to others for assistance (Choi & Suh, 1995; Queralt, 1996). Such reluctance to use services may reinforce the myth held by some service providers that Asian older persons do not have problems and "take care of their own."

Because it is important that social workers develop services responsive to ethnic minority older adults, we need to consider the implications of socio-cultural factors for the delivery of social and health services. Although some service providers have rationalized that ethnic minority older adults do not utilize formal services because they have their families' assistance, patterns of underutilization cannot fully be explained due to strong family support. For example, underutilization of in-home services may result more from services not being presented to ethnic minorities as a viable, culturally appropriate alternative to long-term care. Findings are mixed regarding whether ethnic minority older adults underutilize social and health care services (Markides & Black 1996; Mui & Burnette, 1994). In fact, medical and psychosocial interventions that are culturally sensitive have been found to increase ethnic minority service utilization (Plawecki, 2000; Sakadakis & MacLean, 1993). On the one hand, Medicaid is not fully used by potentially eligible minority elders, even when they are aware of it. Underutilization of Medicaid has been attributed to lack of knowledge about the program, difficulties in applying, and an aversion to accepting publicly funded benefits (Wykle & Kaskel, 1994)

The lack of mental health knowledge about ethnic and racial groups is even more acute than is the ignorance regarding physical health and social and demographic factors (Standford &

DuBois, 1993). The limited available empirical findings suggest that we take a new direction in research and practice when we work with elders of varied ethnicity and race (Harel & Biegel, 1995; Jackson, Antonucci, & Gibson, 1995). There are many important research findings on cultural differences in the way illnesses are managed, because of personality differences, patterns of familial interaction, coping, and adaptation (e.g., Kim et al., 2001; Padgett, 1995; Pang, 1999). It is also true that the biological and psychological aging processes are affected by ethnicity, race, and cultural norms (Jackson, Burns, & Gibson, 1992).

There is a need for a greater integration of racial and ethnic perspectives and cross-cultural considerations in research on aging and mental health (Jackson et al., 1995; Markides, Liang, & Jackson, 1990). Jackson and his colleagues (1995) argued that current theories, research paradigms, and service delivery models are not sensitive to racial and ethnic differences. By suggesting that the empirical literature on mental health among ethnic older adults is rare and of poor quality, they have also indicated the importance of separating the constructs of minority group, race, ethnicity, and culture (Jackson et al., 1995).

CHAPTER 2

LITERATURE REVIEW

Human Ecosystem Theory

Bronfenbrenner's model of the human ecosystem (1979, 1989) will guide this section as a major theoretical framework. Human ecosystem theory focuses on the ways that a person's environment affects and influences his or her development (Garbarino & Aramowitz, 1992). This human ecological approach includes not only the immediate family and home environment, but also the wider social and cultural world as it affects individuals. In this study, this human ecosystem model will be used to understand the connections between older adults in families, in communities and the larger society that surround them. Much like the study of natural ecology, the human ecosystem model focuses on the interactions between human individuals at various levels of the environment as they affect each other. However, it differs in its emphasis on the active role of the human being in creating and recreating its environment.

While Bronfenbrenner's book, *The Ecology of Human Development* (1979), discussed the process of children's development, this model will be used to do research where and how older adults live or interact with four environmental levels. The term "environment" here will include everything outside older individuals such as immediate family, relatives, friends, neighborhood, and religious organizations, as well as less immediate forces such as laws, social attitudes and public policies that directly or indirectly affect older individuals (Figure 1). The interaction between individuals and their environments forms the basis of an ecological approach to human development.

Bronfenbrenner (1989) presented four levels of social systems: microsystem, mesosystem, exosystem, and macrosystem (Table 1). The *microsystem* includes all the immediate face-to-face contexts referring to the psychological realities of the actual settings in which the individual experiences and creates day-to-day reality. For older adults, micro-systems are the places they live, the people who live there with them, and the things they share together. The *mesosystem* comprises the linkage and other processes taking place between two or more face-to-face in which a person participates. For Korean older adults, it includes the number and quality of connections perceived by older adults with non-kin networks such as friends and neighborhood. One aspect of the mesosystem would be the relationship between the family and the ethnic neighborhood or community in which they are involved.

The *exosystem* consists of the linkage and other processes taking place between two or more social settings, including at least one setting that does not ordinarily contain the person or persons who are the unit of attention, but in which events occur that influence such individuals. For Korean older adults living in the United States, their adult children's immigration motives and social status have a profound influence on their quality of life. In addition, labor force issues of adult children have a major impact on older adults. For example, if the adult children were suddenly given a night shift at work, the older parents would be in charge of caring for their grandchildren at home. A dilemma faced by many immigrant families is the duality of cultures and the inevitable clashes when different generations have different languages, values, and ethics. As a result, traditional cultural values regarding the care of older parents by adult children are weakening (Antonucci & Cantor, 1994).

The *macrosystem* consists of the larger societal and cultural circumstances experienced by the individual, depending on factors such as the person's race, gender, socioeconomic status,

ethnic background, place of birth, religion, and place of residence (Queralto, 1996). Some people have been raised in an environment that is different from that in which they currently live. Both the original and current environments form their macrosystem because both have influences on them (Bronfenbrenner, 1989). Such distinctions are particularly important for people who have experienced transplantation from one environment to another (e.g., immigrants and refugees) or people who must negotiate two cultures on a regular basis (e.g., those from minority racial, ethnic, or religious groups). According to Garbarino and Abramowitz (1992), to identify a macro-system is to do more than simply name a group – American, Latino, African, Asian. It is labeling a cultural system such as Judeo-Christian, Communist, or democratic. We must compare these groups systematically on some common scales of measurement, such as “collective versus individual orientation.”

Based on the previous definition, the key elements of each system and the relationship between each system and older adults will be more described in next section. The micro-systems consist of family and friends. Second, ethnic community and religious organizations will represent the meso-systems. Third, the exo-systems consist of immigrant families’ social status, particularly adult children’s attitudes toward American life and their daily struggle which may impact on the quality of life among older adults. Finally, the macrosystems include different societal cultures and public policy for older adults.

Microsystems

The family is a vital part of the older person’s life. Older people give a great deal to their families, and they receive a great deal in return. Family members tend to exchange emotional and financial support throughout their lives. A person’s confidant in life is typically a close family member – a spouse or a child. Later life is not a static time for the older family member.

Transitional events such as widowhood, retirement, or a child's departure from home punctuate the life course (Hillier & Barrow, 1999). Transitions lead to changed perceptions, ways of behaving, and interdependence with kin and community. The older person's life is also influenced by family history, past life events, and certainly gender (Hillier & Barrow, 1999). Typically, Asian Americans maintain strong mutually helpful ties with family members. Particularly among Asian immigrants who have come to the U.S. recently, one frequently finds large extended family groups living together until they settle down well enough to live independently. Such collective living arrangements, reflective of family solidarity and interdependence, allow them to begin their new lives in the United States (Nishi, 1995).

Friendship is extremely important in the lives of older people. Roberto and Scott's study (1984) revealed the importance of friendship and its relationship to personal well-being in later life. While friends have clearly always been important, the adage that "blood is thicker than water" is culturally ingrained, and it becomes easy to overlook the true impact that friends – particularly friendships of very long duration – have on our psychological and social well-being (Hillier & Barrow, 1999). There is conflicting evidence about the extent to which older adults living in retirement communities are actually integrated into their immediate environment, the extent to which their needs for social support are met through their interactions with other residents, and the effects of retirement community living on emotional well-being (Chappell, 1991).

Different sources of support may have a differential impact on the well-being of older adults (DuPertuis, Aldwin, & Bosse, 2001). The ability to reciprocate has a greater impact on friendships than family relationships. Satisfaction in a friendship is curvilinear, with satisfaction being poorest when too much or too little reciprocity is perceived as present. This differential

relationship between reciprocity with children and friends may explain why families are more important to elders in times of illness. Elders could have higher satisfaction when receiving support from family members, which in turn could lead to higher general life satisfaction. However, receiving assistance from friends could actually lower satisfaction if the elder could not reciprocate due to poor health.

Mesosystems

As stated previously, the mesosystems include religious affiliations and ethnic neighborhoods and community. One of the most frequently reported forms of participation among older people is in church (Chatters, Levin, & Taylor, 1992; Hiller & Barrow, 1999). Church-related activities involve more than attending services. They include participation in church-sponsored groups such as missionary societies and Bible-study classes. In a similar manner, senior centers offer services and activities in addition to recreation. Various senior centers additionally may offer libraries, music rooms, health services, counseling, physical exercise, and education. Many senior centers operate under the auspices of churches, city government, or private nonprofit agencies. The demand for senior clubs and centers continues to rise. Ethnic communities may have senior centers, and it may be natural for older ethnic people to use their senior center as a place to share and maintain their mother countries' cultures and identity.

Ethnic minority churches have been a traditional part of American life (Reid, Linder, Shelley, & Stout, 1990). They described the establishment of ethnic churches as "one of the first major acts of a settled immigrant community" (p.84). These churches began as mutual aid societies that provided medical, social, and other services. These churches are involved in the health, transportation, and social services of its community. Korean churches play a significant

role in Korean immigrants' adjustment to new environments in the United States and act as social and cultural centers providing education about Korean language, history, and culture (Choy, 1979). They are also a means by which their members can negotiate interactions with the larger society.

Ethnic communities are particularly important for immigrant older adults because the community is defined, in part, by their identification with and ties to their homelands (Wallace, 1992). Furthermore, the immigrant community is comprised of people who come from a more age-integrated culture that gives the elderly a higher status and respect than they have in the dominant American culture. These ethnic communities contribute to older adults' maintenance of their cultural identities (Kim et al., 2001). As immigrant older adults are more involved in the ethnic community, they tend to connect with familiar people and resources during their adaptation to the larger society. Ethnic communities are also a center for leisure activities and for the delivery of limited services to Asian American/Pacific Islander older people.

Exo-systems

Social support networks, consisting principally of family members, neighbors, and friends, can provide various support functions to older persons. As societies modernize, changes in family structure might alter this supportive capacity, and changes in traditional values affect the nature of the network and support provided. This may especially be so in rapidly modernizing societies as in the Asian countries where the traditional role of the family and especially children's duty to care for parents (filial piety) may be weakening (e.g., Ng, Phillips, & Lee, 2002). In the past, Asian older adults turned to the benevolent societies and clubs in their tightly knit communities, as well as to their families. Yet many are caught between their cultural traditions of group and familial honor and the values of their adopted culture that stress

independence and self-sufficiency, making them reluctant to seek others' help (Braun & Browne, 1998). Filial piety is a cardinal family value in all the East Asian cultures influenced by Confucianism. According to this doctrine, children are duty bound to respect their parents, to listen to them, and to obey them without question, regardless of how good or bad their parents may be.

The intergenerational relationship in Korean immigrant families is somewhat more complicated and different. Older immigrant persons from Korea often have not learned English and have not adjusted to American society well. As these people are getting older, they become extremely dependent upon their children because of their lack of acculturation and their belief in filial piety (Kim, Kim, & Hurh, 1991). This extreme dependence often leads to intergenerational conflicts. In the US, family relationships are much more loose and mobile and employment of adult children, including daughter-in-laws, tends to dominate over family life. The children of Korean immigrants are more adaptive to American cultural and filial piety is viewed by them as more of a personal choice rather than a tradition (Kim et al., 1991).

For several reasons, relationships between older and younger generations may be particularly difficult in Korean elderly. For example, by the time people become older, they are able to evaluate the developmental trajectories of their adult children. In old age, people must acknowledge the disjuncture between the dreams and values they might have nurtured for their children and their children's actual accomplishments. Their children might not be as successful or driven to achievement as they would like, they might have scorned their ethnic or religious roots, they might drink too much, or they might not be raising their own children in a way that meets the approval of their parents.

Older adults with less power and resources are more likely to be cared for by their adult children, and naturally, they have a higher expectation of filial obligation (Ng et al., 2002). Such an older population may only have limited choices, and may have to depend on others who have more resources. It is also true in Korea that many older adults also understand that the more emotional and economic independence, they have from their children, the better their relationship with their children (Yoo & Sung, 1997). The provision of family support is also heavily mediated by many factors such as changing composition and structure, changing female social economic status, changing living arrangements, and potentially, changes in the reality of filial obligation among younger generations (Ng et al., 2002).

Macro-system

Public policy. From the enactment of Social Security in 1935 to the present, U.S. public policies created an old-age welfare state. About 40% of the annual federal budget is currently used to provide benefits to older adults (Binstock, 1998). These policies have substantially improved the well-being of older Americans. Social Security benefits have helped to reduce the proportion of older people in poverty, from about 35% four decades ago (Clark, 1990) to 10.5% today (Baugher & Lamison-White, 1996). For more than three decades, Medicare and Medicaid have provided almost all older persons with public insurance coverage for a great many health care services to which they might not otherwise have had access (Binstock, 1999). There are many other national policies such as federally subsidized housing, low-income energy assistance, legal and transportation services, and a host of other programs focused on issues of aging which all have reduced vulnerability among today's 33 million older Americans (Hobbs, 1996).

Another consequence of these policies is that millions of older people are highly dependent on government programs as safety nets for income, health care, long-term care, and

various other needs. Even with these safety nets, many of them are vulnerable to problems that threaten their everyday well-being. It is well known that older members of racial and ethnic minority groups are especially dependent on government safety-net programs (e.g., Moon, 1996). The conditions of minority older adults today are considerably worse than those of white older persons (Binstock & George, 1998; Clark, 1990). Moreover, it is evident that there is extremely limited information or no comparable information on other minority older adults (Devore & Schlesinger, 1991). Even when policy discussions are briefly focused on these vulnerable older adults, the especially difficult situations of older members of ethnic and racial minority groups tend to be overshadowed. From the perspective of what social scientists have termed “multiple hierarchy stratification,” minority status in itself is an important source of inequality (Markides & Black, 1996).

Table 1

A Summary of the Human Ecology of Socio-cultural Risk and Opportunity

Ecological Level	Definition/Examples	Issues Affecting Older Adults
Micro-system	Face to face contact Family Peer group	Is the older adult regarded positively? Is the older adult respected? Do the older adults have an active role in reciprocal relationships?
Meso-system	Neighborhood Religious institutions	Do settings respect each other? Do settings share basic consistency in values?
Exo-system	Family's social status	Are adult children fulfilling their immigration goals?
Macro-system	Ideology, social policy	Are some groups valued at the expense of others ? (e.g., ageism, racism) Is there an individualistic or a collectivistic orientation?

Stress-Coping Model

In this research, a stress and coping model (Lazarus & Folkman, 1984) is used to conceptualize and examine the relationship among stressors, coping resources, and the mental health outcome among Korean older adults. Pearlin and his associates (1981) also specified a basic conceptual framework of the stress process by illustrating the roles of and interrelationships among three major constructs: stressors, mediators or coping resources, and distress or health outcomes. Briefly, the model portrayed the ways in which the harmful consequences of social stressors vary substantially across individuals and social groups, and explains how such variations are determined by psychological and social coping resources, including personality, coping efforts and skills, and social supports (Lazarus & Folkman, 1984). Studies in many disciplines provide empirical evidence supporting the stress-mediating and stress-buffering roles of coping resources (e.g., Atchley, 1997; Dorfman, Holmes, & Berlin, 1996; Koenig, Cohen, Blazer, Pieper, Meador, Shelp, Goli, & DiPasauale, 1992)

Stress and coping with stress have been among the most popular research topics in the social and behavioral sciences over the past twenty years (Aldwin & Revenson, 1987; Jang & Haley, 2002). Recently, some researchers in social work used the stress and coping framework to conceptualize and examine the relationship among stresses, coping resources, and depression in Asian American older adults in the USA (e.g., Casado & Leung, 2001; Shibusawa & Mui, 2001). However, this stress and coping model is still less applied to study older adults than to younger persons (Jang & Haley, 2002). It should be emphasized that research on stress and coping in later life can not only improve our understanding of human development and adaptation, but also serve as a basis for interventions and social policies to enhance well-being in later life (Jang & Haley, 2002).

Much of the current literature supporting the stress process formulation has been limited to non-Hispanic, white communities (e.g., Jang & Haley, 2002; Lazarus & Folkman, 1984). Few attempts have been made to examine cultural and ethnic variations in the effects of social stressors on mental health. Therefore, this section has two unique purposes. Comparing the mental and physical health status of two Korean older adult groups will provide an opportunity to assess whether the stress process is a theoretical framework that can be used to understand the link between socially induced stressors and their consequences for the mental health of older Koreans and Korean-Americans. Second, studying coping mechanisms such as subjectively judged social supports and religiosity could contribute to empirically improve protective roles against depressive symptoms that both Korean older adults may experience.

Stressors

There is a growing interest in the stressful transitions of aging, and concern with the physical environment and how it affects us. These all have had a stimulating effect on the study of stress and on individual differences in stress reactions (Lazarus & Folkman, 1984). There are various models of stress and coping, and different types of stressors and coping resources have been found to affect the well-being in older adults (Lazarus & Folkman, 1984; Jang & Haley, 2002). According to the stress and coping model, stress is conceptualized as events and conditions that are perceived by the individual as a potentially difficult situation (Lazarus & Folkman, 1984). Stressors have been linked with negative mental health outcomes such as depression and anxiety (e.g., Ellison, 1995; Folkman, Lazarus, & Pimpley, 1987). Common sources of stress among older adults include multiple losses such as the death of a family member (spouse and siblings) and close friends and the decline of physical, social, and financial

competencies (Gottlieb, 1997; Shibusawa & Mui, 2001). Other sources of stress also include major life events, enduring problems, and daily hassles (Pearlin et al., 1981)

The definition of stress here emphasizes the relationship between the person and the environment, which takes into account characteristics of the person on the one hand, and the nature of environmental events on the other. Therefore, psychological stress is a relationship between the person and the environment appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus & Folkman, 1984). Jang and Haley (2002) broadly categorized stressors into two types: life events and chronic strains. Life events are discrete stressors that have a relatively clear onset. Two examples of such stressors are the death of a spouse and recent emigration to another country. In contrast, chronic strains are continuing and enduring problems such as chronic disease and disability. These two types of stressors are viewed by researchers as important risk factors that can threaten physical and psychological well-being (Glass, Kasl, & Berkman, 1997; Gottlieb, 1997) .

Research revealed that exposure to high levels of stress leads to increased possibilities of physical and psychological problems in older adults (e.g., Bisconti & Bergeman, 1999). Highly stressed individuals are more likely to have psychological distress such as depressive symptoms, and even increased mortality (Glass et al., 1997). However, stress does not necessarily lead to universally negative outcomes because of individual differences in coping. Some older adults report minimal ill effects from stress or even demonstrate personal benefits from stress (e.g., Gottlieb, 1997). Thus, the study of stress requires attention not only to environmental stressors, but also factors pertaining to unique personal factors, which can provide protection against the negative effects of stress.

Older adults are more likely to encounter some stressful situations, including health deterioration, reduced income, and death of friends or a spouse. Some theorists believed that even though older adults experience fewer negative life events such as family conflicts and job stress, once they occur, their adverse impacts are greater because aging may lead to a decline in some coping resources (Folkman, Lazarus, & Pimpley, 1987). However, some studies have found that common stressors in old age (such as health problems and the death of a spouse) may be stressful, but are expected as normative experiences in later life (Goode, Haley, Roth, & Ford 1998).

Three major chronic stressors commonly found in late life are financial hardship, functional disabilities in daily living and chronic health problems, and lack of active social engagement (Jang & Haley, 2003; Rowe & Kahn, 1997). The chronic health problems of old age are particularly likely to proliferate to other areas of life. Financial strains can affect virtually every domain of activity and relationship of older people. On the other hand, there is some evidence that because health problems and financial constraints are normative in late life, they may be less potent sources of stress for older than for younger people (Krause, 1986, 1987; Lee, Netzer, & Coward, 1995). The potential stressors such as socio-economic status, physical health, functional ability, and immigration status will be discussed in detail.

Socio-economic status. A major stressor among older adults is the need to seek and depend on family members for care. A study revealed that close to 20% of the respondents were mildly depressed and the prospect of becoming dependent on family is a source of distress in this population (Shibusawa & Mui, 2001). Close to 40% of community-dwelling older adults in the U.S. are dependent on others for basic health and social support (Brody, 1985). Older immigrants tend to be more dependent on their families because they lack language skills and access to

resources (Lubben & Becerra, 1983). Whereas in Asian cultures, family bonding and reciprocity between generations is particularly emphasized, some findings suggested that dependence on family can be a source of psychological distress especially among immigrant older adults in the United States (e.g., Mui, 1996; Shibusawa & Mui, 2001).

Although it is true that economic hardship in Asian older population is still prevalent, only a few investigators have studied the effect of this source of strain on the psychological well-being of the elderly (Chi & Chou, 2000; Krause, Liang, & Gu, 1998). These research findings indicated that financial strain does indeed exert a deleterious influence on the psychological health and well-being of the elderly. For instance, it can contribute to an increase in depressive symptoms. Some cross-sectional studies have shown that higher financial strain was associated with more depressive symptoms (Chi & Chou, 2000; Krause et al., 1998). Factors such as lower education, reduced income, and no family support are known to lead to an average lower social economic status among the Korean older population (Huh & Kim, 1984, 1990; Yoo & Sung, 1997). High financial strain leads to loss of independence over finances, which then causes an increase in depressive symptoms reported (Lee, Crittenden, & Yu, 1996).

Physical health and functional ability. Many studies have shown the important influence of subjective health on psychological health outcomes (e.g., Idler & Kasl, 1992; Idler, Kasl, & Lemke, 1990). In a review of studies linking subjective health to mortality, Idler and Kasl examined six studies that showed that self-rated health has a significant impact on mortality, net of objective measures of health. In her own work, Idler and colleagues (1990) showed that poor subjective health is linked to higher mortality over a four-year follow-up period. While it is less clear to distinguish the role of social and demographic factors in shaping perceptions of health, these findings also indicated that subjective health has robust effects upon well-being such as

better mental health, especially among the elderly (Idler & Kasl, 1992; Idler et al., 1990; Musick, 1996).

Maintaining independent functional ability in daily living is known as an indicator of healthy aging (Rowe & Kahn, 1997). Functional status is the ability to perform the instrumental activities of daily living (IADL) that affect a persons' capacity to live independently in the community (Ebersole & Hess, 1994). IADL are complex tasks made up of many components such as traveling, shopping, preparing meals, doing housework, and handling personal finances (Sonn & Asberg, 1991). IADL tasks are different from the physical activities of daily living, which are activities largely concerned with basic bodily maintenance. IADL tasks are more complex and competence in their execution and may have a broader impact, possibly linked to social competency (Fillenbaum, 1988). In addition, IADL may be more useful as a means of detecting disability in a general elderly population than personal ADL, such as cooking, bathing and toileting (Sonn & Asberg, 1991). It was assumed that lower levels of functional status can limit the chance of social contact and lead to loneliness (Rowe & Kahn, 1997).

It is widely known that functional impairment affects older persons' emotional well-being (e.g., Fillenbaum, 1988; Rowe & Kahn, 1997). Repeated studies have demonstrated a relationship between functional impairment and levels of depression in community-dwelling elderly people (Djernes, Gulmann, Abelskov, Juul-Nielsen, & Sorensen, 1998; Pennix, Leveille, Ferrucci, van Eijk, & Guralnik, 1999). Impairment both in instrumental activities of daily living (IADLs) and in activities of daily living (ADLs) has been associated with higher levels of depressive symptoms (Valvanne, Juva, Erkinjuntti, & Tilvis, 1996). Poor functional ability may reduce interaction with family and friends outside the home (Bergman, Plomin, Pederson, & McClean, 1991) and thus impede social engagement (Thompson & Heller, 1990). Some research

found that elderly people with poor functional capacity were more lonely than those with good functional capacity (Holmen, Ericsson, Anderson, & Winblad, 1993; Jylha & Jokela, 1990), while other research failed to find the relationship between functional ability and mental health (Russell, 1996).

Immigration status. Recently social work researchers tended to use the stress and coping model to understand the relationship among stresses, coping resources, and depression in Asian American older adults in the U.S.A. (e.g., Casado & Leung, 2001; Shibusawa & Mui, 2001). These studies have noted that Asian elderly suffer more negative experiences than white elderly. The concept of triple jeopardy (being old, being female, and being a minority) has been evoked to explain their negative later-life experiences (Markides et al., 1990). For the Koreans who immigrated to the USA in old age, their confrontation with cultural differences and a lack of English proficiency could lead to even greater negative life experiences (Yoo & Sung, 1997). Such a situation in which the Korean older adults found themselves might be labeled as ‘quadruple jeopardy’. From this perspective, researchers assumed that minority status or marginality itself could be considered a significant stressor (e.g., Kiefer, Lau, Yamamoto, Zheng, Kim, & Cho, 1985; Kuo, 1984; Shibusawa & Mui, 2001). One prediction that emerged from this formulation is that immigrants will experience more mental health problems than native-born individuals because of “the uprooting process itself produces an excessive amount of social stress” (Kuo & Tsai, 1986, p.134).

Immigration is a stressful process for uprooted persons adjusting to the new society (e.g., Kuo and Tsai, 1986). Changes in cultural norms and social conditions are particularly difficult for older immigrants who often lack crucial information about the new society. Thus, older adult immigrants are recognized as a high-risk group in terms of mental health (Antonucci & Cantor,

1994; Kiefer et al, 1985; Kim, Hurh, & Kim, 1993). In particular, older immigrants experience racial discrimination and suffer from the lack of culturally appropriate supportive services, in addition to the general stress of aging itself (Shibusawa & Mui, 2001; Yoo & Sung, 1997). Furthermore, recently arrived older immigrants experience the loss of their family environment, support systems, identity, and status as well as language barriers, unfamiliar social resources, changes in family relationships, and feelings of helplessness (Tsai & Lopez, 1997).

Among Korean Americans, women and older adults are known to experience more stress during the acculturation period and often are economically disadvantaged (Hurh & Kim, 1989, 1990). Many Korean immigrant older adults may face multiple adjustment problems as they grow older in the new country. Several of these problems are caused by language barriers, cultural differences, lack of employment opportunities, and reduced family ties and resources. Those factors may contribute to a decline in their mental health status. Some studies have concluded that Korean older adults in the United States were less satisfied with their lives than older adults living in Korea (Kim, 1987; Moon, 1996). This was reflected in their reports of loneliness, loss of a sense of control, conflict with children, isolation from social and political activities, and underutilization of social and legal services (Moon, 1996).

Coping Resources

In the stress-coping model, coping is defined as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). Coping resources can also be properties of the individuals, including health and energy (a physical resource), positive beliefs (a psychological resource), and problem-solving and social skills (competencies) (Gottlieb, 1997; Jang & Haley, 2002). The other resources are more environmental and include

social and material resources. For some older persons, adaptations in later life may sometimes be problematic, but they may also be resolved by various methods of formal and informal care and support (Johnson, 1995; Kendig, 1988).

Stress-coping models have identified a number of factors that may decrease the negative impacts of stressors, including self-appraisals, internal and external resources, and coping responses (Jang & Haley, 2002; Lazarus & Folkman, 1984). These factors may be considered as protectors against the negative consequences of stress. The responses and mechanisms may have direct effects or they may serve as either mediators or moderators of the relationship between stressors and psychological well-being (Lee, Crittenden, & Yu, 1996; Krause, Liang, & Keith, 1990). In a direct effect, older people with a high level of a resource (e.g., income) may be found to have higher well-being regardless of whether highly stressful circumstances occur. On the other hand, research on the stress-buffering hypotheses suggests that under circumstances of high stress, individuals with strong social support may be at lower risk for depression than individuals with weaker social support, but that social support may matter little under conditions of low stress (Krause, 1986; 1987; 1990).

There has been increasing interest in the role of spiritual beliefs and religious participation as factors promoting successful coping (e.g., Ellison & Levin, 1998; Fehring, Miller, & Shaw, 1997). Results suggest that religious or spiritual beliefs and religious participation may improve coping with a variety of stressors. Possible mechanisms for such effects include aiding people in finding meaning in the face of adversity and allowing access to social support networks including clergy and others in the faith (Nooney & Woodrum, 2002).

Besides internal sources of coping such as religiosity, external factors such as economic resources or social resources may be valuable in dealing with stressors. Higher socioeconomic

status is often found to be a protective factor because financial resources can be used to provide concrete assistance such as transportation, medical care, and better housing arrangements (Kim, 1990; Krause, 1986). Other important external resources include social networks and social supports. Particularly, social support refers to the actual receipt of some emotional, tangible, or informational help from others, and the subjective perceptions of support (Krause, 1986, 1987). Numerous studies have confirmed that social resources play important roles in improving life satisfaction and well-being (Bisconti & Bergman, 1999; Cantor, 1979; Chappell, 1991; Dean, Kolody, & Wood, 1990). Studies indicate that individuals with strong social networks and supports are often in better physical and mental health (e.g., Lee et al., 1996; Stoller, 1985; Thompson & Heller, 1990). In the next section, social supports and religiosity as two major coping resources for older adults will be examined in detail.

Social support. This section will mainly address the effects of three support sources (from family, friends, and others) on health status among older adults. In the stress-coping model, social support is regarded as one of the most important coping resources. The abundance of literature focusing on social support and health and well-being outcomes in older populations may be due to important theoretical, clinical, and especially public policy concerns (e.g., Antonucci & Jackson, 1987; Bisconti & Bergeman, 1999; Padgett, 1995). Because social support is related to both psychological and physical health in later life, research is needed to examine the underlying nature of this relationship.

In recent years, a great deal of research has focused on social networks. Social network describes the structural characteristics of support relationships (e.g., size or composition). On the other hand, social support is assessed as a more qualitative aspect of the relationship, including how satisfied individuals are with the support they receive and whether supportive others

understand them (Antonucci, Fuhrer, & Dartigues, 1997). A study using the convoy model provides us with detailed information showing that older individuals are in frequent contact with both family and friends. The term “convoy” (Antonucci & Akiyama, 1987) is used to evoke the image of a protective layer of family and friends who surround a person and offer support. The average older convoy was reported in one major study of older persons to consist of about nine members who offer themselves as confidants, give reassurance and respect, provide care when ill, talk when upset, and discuss health (Antonucci & Akiyama, 1987).

One role of social support is to prevent harmful effect of life stress. Research with data from the 1988 Ethnic Elderly Needs Assessment Survey conducted in Chicago revealed that emotional support was found to moderate the harmful effect of life stress and thus to be more relevant than instrumental support to the mental health of Korean elderly (Lee, Crittenden & Yu, 1996). This study was based on the integrative concept of social support such as the quantitative, functional, and the structural aspects of social relationships within a theoretical framework for understanding the prevalence of depressive symptoms among elderly Korean immigrants. It is evident that Korean older adults with larger close networks and more contacts with close persons are in better mental health (e.g., Moon & Pearl, 1991). Lee and her associates (1996) also found that friends play a positive role in life satisfaction of elderly Korean immigrants.

Research on the psychological consequences of receiving social support in late life has produced mixed results. Some studies showed that social support improves the psychological well-being of older people or buffers the impact of stressful events (Silverstein & Bengtson, 1994; Thompson & Heller, 1990). Other research found that social support has little bearing on well-being (Krause, Liang, & Keith, 1990; Umberson, 1992). However, several studies found that support received from others increases distress among older people (Lee, Netzer, & Coward,

1995; Penning & Strain, 1994). In contrast to the assumption that more support is better, a study debunked the idea that excessive support received from adult children may increase distress by inducing dependence and eroding the autonomy of the older adults (Silverstein, Chen, & Heller, 1996). In one of the rare studies to test for both positive and negative effects of social support, Krause (1987) found that support provided to older persons strengthened their feelings of personal control over the environment. The limits of support were demonstrated in another way by Krause (1997a), who showed that moderate amounts of emotional support buffered the impact of financial strain on the emotional well-being of older people, but high levels of emotional support failed to do so.

Family support is the most important component of general social supports. Family support refers to the cohesion or closeness that family members feel toward one another (Olson, Russell, & Sprenkle, 1984). The behavioral results of this family closeness are the amounts of emotional support family members give to one another. Several variables indicate the level of supportive, emotional connectedness that family members feel toward one another. With a higher level of family support, family members have the ability to form healthy autonomous bonds with others outside of the family system (Chappell, 1991; Dean, Kolody, & Wood, 1990). Either too much or too little support is unhealthy for family functioning. When the family is not supportive, members tend to ignore each other's needs. This situation can be dysfunctional especially during stressful periods. For non-English speaking immigrant older adults who are heavily dependent on their adult children, this unsupportive family environment can place them in severe emotional distress.

Regarding role of friends, three disparate views have received empirical support (DuPertuis, Aldwin, & Bosse, 2001; Friedman, 1993; Hong & Duff, 1997). First, communities

are characterized by frequent social interaction and peer interdependency, each of which contributes to increased well-being (Hong & Duff, 1997). Second, although within-community interaction may indeed be frequent, friendships among residents tend to be superficial, limited in scope, and lacking in intimacy; community living may thus have negligible or even negative effects on well-being (Antonucci, 2001). Although some community dwelling older adults may engage routinely in activities with other older adults, many view themselves as isolated within both their immediate environment and the larger community, particularly those who are frail (Ingersoll-Dayton, Morgan, & Antonucci, 1997). Although levels of social support from friends within the ethnic community were quantitatively high, Potts (1997) failed to show a significant effect on depression. Those contradictory findings might result from the fact that it is unknown if social support from friends within the ethnic community is equivalent to social support from friends outside of it as a predictor of well-being.

Different sources of social support may have a differential impact on the well-being of older adults (DuPertuis, Aldwin, & Bosse, 2001). Some studies in Korea have found that family relationships, frequently measured as relationships with children, are most important in the physical well-being of the elderly (Kim et al., 1996; Choi & Suh, 1995). Older adults who are ill experience a greater benefit from family support than from friend support in the areas of life satisfaction, emotional well-being (Friedman, 1993), and adjustment (Primomo, Yates, & Woods, 1990). This differential relationship between reciprocity with children and friends may explain why families are more important to elders in times of illness. Elders could have higher satisfaction when receiving support from family members, which in turn could lead to higher general life satisfaction. Receiving assistance from friends could actually lower satisfaction if the elder could not reciprocate due to poor health.

Other studies have found that friends have a more positive impact on morale than families do (e.g., Lee & Ishii-Kuntz, 1987). It means that frequency of contact with friends is a better predictor of morale than contact with children. A study showed that the impact of friendship on morale was mediated through loneliness so that older widows with more friends had higher morale and lower loneliness (DePertuis et al., 2001). Supports from friends were also more strongly related to feelings of self-worth in some older adults (DuPertuis et al., 2001). Those results appear to confirm a pattern of differential importance in source of support. While families are found to be of primary importance, focus on physical needs or problems, such as adjustment during illness and support from friends would be more strongly associated with psychological health (Thompson & Heller, 1990).

Religiosity. In the stress-coping model, religiosity is known as one of the important coping mechanisms. This section will be discussed with three themes: 1) the definition of religiosity; 2) the importance of religiosity in later life; 3) the effects of religiosity on physical and mental health. Those three have been found to correlate with the experiences of religiosity as one of older adults' coping strategies.

The religious dimension of aging encompasses the spiritual, social, and developmental aspects of a person's life, and is an important dimension of well-being for older adults (Ellison & Levin, 1998). However, efforts to study the relationship of the spiritual dimension to aging have been hindered by an inability of the research community to use consistent terms and definitions. Consequently, inconsistent conclusions abound in the literature (Hillier & Barrow, 1999). Thus, it is necessary to define the multi-dimensionality of religious involvements empirically (Chatters, Levin, & Taylor, 1992).

The terms spirituality and religion are often used interchangeable, however, their meanings are significantly different. While this section will discuss the importance of organized religion and its role as a social support system in the lives of elders, the discussion of elders' spirituality is another focus. This emphasis on spirituality allows people to move beyond the confines of specific religious denominations to recognize the rich diversity of ways in which elders express the role of this force in their lives. Spirituality can be defined as the "search for transcendence, meaning, and connectedness beyond the self" (Sherwood, 1998, p.81) and also conceptualized as "the renewable life force, the energy that enlivens the physical, and the space where human communion is possible" (Tolliver, 1997, p.479). Common definitions of spirituality include major factors such as transcendence beyond oneself, a search for meaning, and a sense of connectedness to others. In contrast, religion is the formal institutionalized expression of spirituality characterized by "beliefs, ethical codes, and worship practices" (Joseph, 1988). Religious denominations espouse a basic set of principles about the existence of a supreme being, the existence (or lack) of an afterlife, how people should behave toward others, and the rituals important to the expression of faith in those principles. Persons can be spiritual without identifying with a specific religious denomination. It is also possible that persons can be active participants in a religion, but not be particularly spiritual.

There are two distinctive dimensions of religiosity. Extrinsic religiosity is defined as organized religious participation or external practices such as active participation in and attendance at a religious institution such as a church, synagogue, temple, or mosque. Meanwhile, intrinsic religiosity is defined as internal or non-organized religious activities such as prayer, beliefs, and expectations (Brennan, 1999). The ability to maintain religious faith is important in two ways (Musick, 1996). First, religious beliefs can provide comfort and hope in the face of

distressful circumstances. Second, another sort of religious belief may also be important for persons with terminal illnesses such as cancer. In essence, religious coping provides a framework through which individuals can find meaning and understanding in suffering (Krause & Van Tran, 1989; Krause, 1993, 1997).

Both extrinsic and intrinsic types of religious behavior are aspects of religious involvement that have different impacts on mental health outcomes (Ellison, 1995). Public religious activity is associated with social control and integration, while private religious activity is associated with constructing relationships with the divine. Subjects with high intrinsic religiosity had significantly higher levels of depressive symptoms than subjects with low intrinsic religiosity (Kolomer, 2001). Other researcher felt that subjects with high religiosity could use their religious patterns for coping (prayer, religious objects) and subjects with high spirituality were able to maintain a greater sense of wholeness than those with low spirituality (Fehring et al., 1997).

Church and synagogue attendance is one of the most important parts of daily lives for some older people (Reid, Linder, Shelley, & Stout, 1990). People age 65 and over are the most likely of any age group to belong to clubs, fraternal associations, church-affiliated organizations such as Bible study groups, and volunteer groups serving the sick and needy. Evidence for shifts in religiosity in aging is inconsistent (Courtenay, Poon, Martin, Clayton, & Johnson, 1992). There is a lack of consensus about the role of religiosity at various points of the life course. However, studies including centenarians indicated that among the oldest-old, “non-organizational” aspects of religion (less active aspect of religion such as beliefs, faith, and influences of religion on daily living) are more common than are the organizational aspects (Courtenay et al., 1992). This is likely due to more limited ability of the oldest-old to attend

organized religious functions. These findings highlight the importance of the multidimensionality of religion and spirituality.

The role of religiosity might differ significantly depending on ethnic groups (Courtenay et al., 1992). More than 75 % of all older African Americans are church members and at least half attend religious services at least once a week (Stolley & Koenig, 1997). Traditionally, religion and church have been powerful sources of social support for older African Americans and church attendance is the most significant predictor of both frequency and quantity of support received (Stolley & Koenig, 1997).

Ethnic minority churches have been a traditional part of American life (Reid, Linder, Sheeley, & Stout, 1990). Reid and his colleagues described ethnic churches as “one of the first major acts of a settled immigrant community” (p.84) by providing services for sickness, death, and social service needs. For Korean immigrants, churches play a significant role in their adjustment to new environments in the U.S. (Choi & Tirrito, 2000). Hurh and Kim (1990) concluded that among the majority of Korean immigrants, the religious need (meaning), the social need (belonging), and the psychological need (comfort) for attending the Korean church are inseparable.

There are some mixed findings about the relationship between religiosity and mental health. Many studies found that being affiliated with a religion (versus no affiliation) and having higher frequencies of attendance and prayer are associated with positive mental health outcomes or a decreased likelihood of mental health illness (Ellison, 1995; Koenig, Cohen, Blazer, Pieper et al., 1992; Koenig, Hays, & Cohen, 1998). In contrast, other studies have been equivocal with very small or non-significant correlations found between the standard measures of religion and mental health (Atchley, 1997; Crawford, Handal, & Wiener, 1989; Nooney & Woodrum, 2002).

While Nooney and Woodrum (2002) did not find any relationship between religious attendance and prayer frequency and depression, their findings support that a conceptualization of religious effects where public and private religious activity stimulate church-based social support and religious coping.

Recent research also has been attentive to potential negative social consequences of church involvement (Krause, Strawbridge, Shema, Cohen, Roberts, & Kaplan, 1998). Church duties may be demanding, and some persons may feel that their congregation is overly critical of them. Far from reducing stress, these forms of interaction may exacerbate it. These negative effects of religious involvement exist alongside the positive effect and both must be examined to form a realistic picture of public religious activity (Nooney & Woodrum, 2002).

Interaction with a religious community may also be an important avenue through which frail older adults receive instrumental and emotional support. Researchers have shown that social support is an important resource for helping people cope with stressful situations (Lin, Ye, & Ensel, 1989; Musick, 1996). Church members may visit frail older adults in the hospital or in their homes to provide companionship, bring needed items, or help perform necessary chores. Similarly, Ellison and Levin (1998) reported that persons active in a religious group had higher levels of non-kin network ties, received support, and quality of support. A recent article from a sample of older adults reported that respondents who attend church regularly report having more close friends and more contact with friends and kin (Idler, Kasl, & Hays, 2001).

In summary, the literature reported that religion plays a major role in the lives of older adults. Studies of depression in the elderly suggested that older adults who are religious are less depressed and have better mental health (Koenig, 1990). In addition, some researchers have reported a strong link between religiosity and life satisfaction (Koenig, Smiley & Gonzales,

1988). According to Johnson (1995), older adults who are religious are happier, have better coping mechanism, are less depressed, and have better physical and mental health. The positive association between religion and mental and physical health is also well documented (Koenig, 1990; 1995; Koenig, Hays, & Cohen, 1998)

Mental Health Outcomes

So far, the stress and coping paradigm led the conceptual orientation in this study. Previous sections based on the stress and coping paradigm have consistently documented the strong positive relationships between causes of stress such as lower SES, poor physical health, and immigration status and depression. In addition, the importance of coping resources such as social supports and religiosity has been empirically evidenced in predicting health outcome following stressful situations. This section focuses on the depressive symptom as a major mental health problem among older adults.

Depression is known to be the most frequently found mental disorder among the aged (Blazer, 2002). Some studies have demonstrated that depression among the elderly is more crucial because their depressive symptoms are affected by multiple factors, including poor physical health, functional impairment, unhealthy behavior, and a lack of social and family support (e.g., Blazer et al., 1991; Zarit & Zarit, 1988). Symptoms in older persons may differ somewhat from symptoms in other populations. Depression in older people is often characterized by memory problems, confusion, social withdrawal, loss of appetite, inability to sleep, irritability, and, in some cases, delusions and hallucinations (NAMI, 2002). Older depressed individuals often have severe feelings of sadness, but these feelings are not acknowledged or openly shown. Thinking that depression is an inevitable sign of aging, many older individuals ignore or deny their symptoms. A commonly believed myth that depression comes naturally

with old age is not true. Clinical depression is an illness that needs medical attention just like any other illness.

The pattern of presenting depressive moods and the correlates of depressive symptoms reflect racial and ethnic diversity. Hence, it is important to know that depression is a socio-cultural construct and that both the depressive experience and the manifestation of depression stemmed from the living experience are different in socio-cultural environmental ways (Kleinman, 1980). Recently, the relationships between depression and its determinants among Asian older adults have been studied by some researchers (e.g., Shibusawa & Mui, 2001). The results of these studies are generally consistent with those found in the white population. It has been reported that socioeconomic status, physical health, functional ability, and social relationships were significantly related to depression among Korean older adults (Lee et al., 1996). While social support functioned as a mediator among elderly Asians (Krause, Liang, & Gu, 1998), physical and financial problems produced more depression (Chou & Chi, 2000).

Recent studies have reported a higher prevalence of depression among Koreans compared with other ethnic groups (e.g., Kim, 1995; Noh, Avison, & Kasper, 1992). The serious psychological problems experienced by various ethnic groups resulting from the stresses of immigration have been reported in previous research (Berry, 1980). Severe acculturative stress commonly is associated with language barriers, culture shock, a lack of social support, and discrepancies between expectations and achievements after immigration (Berry, 1980). In particular, older female Korean-Americans experience marginalization during their acculturation period, and often are economically disadvantaged (Huh & Kim, 1984, 1990).

There are relatively fewer epidemiological data of Asian immigrants residents in the community. According to Noh and Avison (1996), only three epidemiologic studies have been

carried out to examine mental health problems of Korean immigrants in the United States and Canada. The first research on Korean immigrants was conducted by Kuo (Kuo, 1984). Among the samples of four Asian groups – Chinese, Filipinos, Japanese, and Koreans, the prevalence of depression in Korean immigrants in his Seattle sample was about twice the rate in each of the other three Asian groups. Hurh and Kim (1984, 1990) reported that the prevalence of depression among Korean immigrants in Chicago was somewhat lower than the rate from Kuo's study. A recent study conducted in Toronto reported that the prevalence of depression was between 3.1% and 5.9 % (Noh & Avison, 1996). That data did not distinguish by age.

In a recent cross-cultural study, Jang and her associates (2001) revealed that Korean older adults showed much higher depression levels than American older adults. They also suggested that cross-cultural differences helped to understand high rates of depression among Korean elders within the context of the dramatic changes taking place in contemporary Korean society (Cho, Nam, & Suh, 1998). For the past few decades, Korea has gone through tremendous social, economic and political changes. Especially for Korean older adults, being in the midst of rapid changes may make them more vulnerable to depressive symptoms. Jang and her colleagues (2001) also found that poor health was the most salient predictor of depression among both older Koreans and older Americans. This finding is in accordance with the results from numerous studies, which have found that poor health or physical illness is a major risk factor for depression among older adults (Burnette & Mui, 1994).

Kiefer and associates (1985) found that Korean immigrant older adults suffered from severe psychological stresses after immigrating to America. Korean immigrant older adults showed significantly greater negative self-concepts and manifested higher rates of somatic symptoms than their Caucasian counterparts. Kiefer and associates (1985) also suggested that the

higher rates of somatic symptoms among older Koreans might reflect their hard struggle to defend against depression. These findings are consistent with other research conducted on this ethnic population (Hurh & Kim, 1990). Since Korean immigrant older adults are known to report more depression than any other immigrant group (Kiefer, 1985; Kuo, 1984), the sharp rise in depression within the Korean American community is a serious problem that needs special attention from mental health professionals.

In summary, through the application of a stress-coping model into Korean older adults, social supports and religiosity in mediating depressive symptom among older adults were examined from the literatures. In the following chapter, the methodology will be applied to validate knowledge about this older population.

CHAPTER 3

RESEARCH METHODOLOGY

Purposes of Study

While there are emerging greater needs for cross-cultural and/or cross-national perspectives in research on aging and mental health, available empirical studies are extremely limited. Furthermore, the empirical literature on mental health among older Koreans and Korean-Americans is rare and its comparative study is non-existing. Thus, this study has a unique aim to contribute to cross-cultural research and practice on aging and mental health by comparing two groups of older Koreans; those living in Korea and those living in the United States. The first purpose is to examine Korean older adults' unique physical and mental health status. The second purpose is to address Korean religious and cultural issues in providing comprehensive models of care. The third purpose is to suggest the availability and use of medical, social, and economic resources by Korean older adults. Finally, this study will point out possible directions for future research on minority older adults especially since there has been so little research in this area to date.

Research Questions and Hypotheses

Based on previous research in this area, it is expected that the relationship between social support and mental health can be explained as a coping variable. Three aspects of multidimensional social support (subjectively judged level of support from family, friends, and significant others) are tested in separate analyses to predict the outcome variables. The relationship between religiosity and mental health will be also tested in the same way. Two

aspects of multidimensional religiosity (intrinsic and extrinsic religiosity) are tested in separate analyses to predict the outcome variable. However, the presumed association between social support and religiosity are not tested in the path model because those two measures are known to have different psychological constructs and functions on mental health outcomes. These analyses will be examined using two independent samples – Korean older adults in Korea and older Korean immigrants in the United States. The unique and common personal characteristics and environmental situations among two Korean older adult groups will be compared. Under broad questions, some specific hypotheses are formulated as follows:

Question 1: What socio-demographic characteristics are different between Korean older adults and Korean-American older adults?

Questions 2: What factors might contribute toward higher depressive symptoms for both groups?

Hypothesis # 1: Respondents with better SDS status (total score by combining variables such as marital status, education, income, and living arrangement) are likely to be less depressed.

Hypothesis # 2: Respondents with a higher acculturation level (total score by combining variables such as duration in the US, immigration motive, citizenship status, and English proficiency) are likely to be less depressed.

Hypothesis # 3: Respondents in poorer physical health and lower functional ability (IADL) are likely to be more depressed.

Hypothesis # 4: Respondents with more social supports (total score by combining subscales such as supports from family, friends, and significant others) are likely to be less depressed.

Hypothesis # 5: Respondents with higher religiosity (total score by combining subscales such as intrinsic religiosity and extrinsic religiosity) are likely to be less depressed.

Question 3: Based on stress-coping theory, is the proposed model fitted? (In term of the strengths and directionality of the relationship between the exogenous variables (e.g., SDS, health, functional ability, social support, and religiosity) and an endogenous (e.g., depression) for older Koreans & older Korean immigrants in the U.S.)

Data Collection

Design and Procedure

In order to address those four areas, this study used a cross-sectional correlation design to examine the relationship mainly between stressors and coping resources among Korean older adults through the survey method. The questionnaire was first developed in English (Appendix A) and translated in Korean by the author and then reviewed by five bilingual doctoral students in English literature, educational psychology, social work, child and family studies, and gerontology. The final version was revised and edited by a professional translator and editor in Korea (Appendix B). The questionnaire included socio-demographic information about Korean older adults living either in Korea or in the United States. It also included the Geriatric Depression Scale, which measures symptoms of depression among elderly persons; the Religious Involvement Scales, which measure the religious beliefs, attitudes, and activities that make up intrinsic and extrinsic religiosity; and the Multidimensional Perceived Social Supports Scale that measures perceived social support among older adults.

Sample

The population of interest in this research was recruited through purposive and snowballing methods. As a cross-national study, one of this study's goals is to compare physical

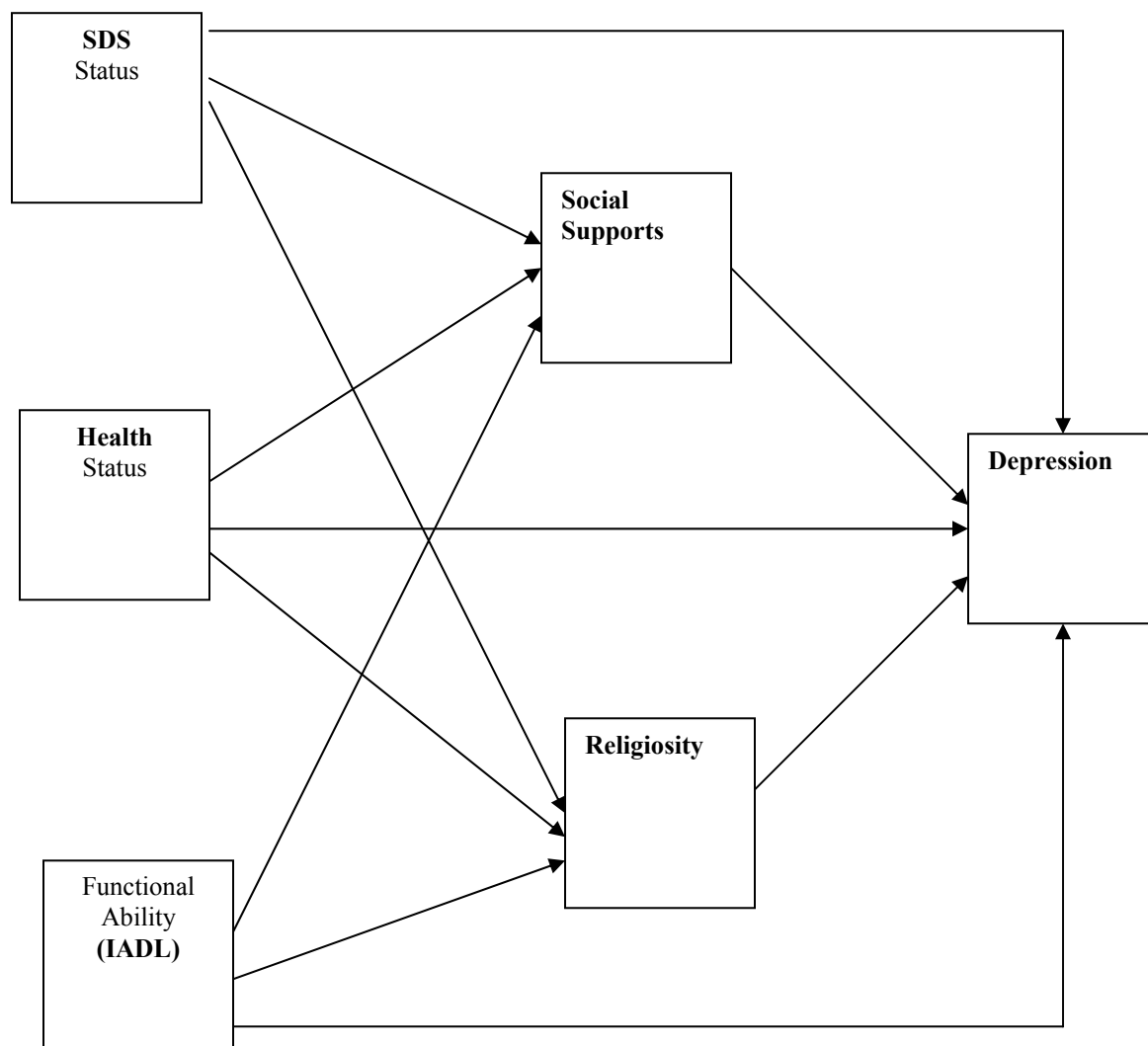


Figure 1. The Proposed Hypothesized Model.

and mental status between older Korean group and older Korean American group. Thus, the sample consisted of two distinct groups of participants (N = 449). This researcher obtained permission from The University of Georgia's Institutional Review Board (IRB) in order to conduct the survey study with older adults. Before submission the IRB application to the UGA, this researcher first contacted key persons primarily leading various community programs or religious organizations in order to obtain written permission and supporting letters. Those persons including program directors, teachers in senior schools, presidents in senior housing complex, or pastors in religious organizations allowed the researcher to distribute the survey to their senior members after a brief presentation to explain the purpose of this study. The first group consisted of 246 individuals age 60 and older adults living in Korea. These older Koreans living in the major urban cities were recruited through senior centers, senior schools, and religious organizations during August of 2002.

The second group consisted of 203 Koreans age 60 and older living in a large southeastern city of America. Although no official census records are available on the Korean American population in this state, the Korean American Association in a southeastern city currently estimates about 50,000 – 60,000 Koreans living in the area (Kim et al., 2001). According to the Korean American Welfare Center in this city, about 10% of the Korean population is considered as older Koreans over 65 years old. Two hundred and three Korean-American older adults participating in this research were all identified as born in Korea and immigrants to the United States. As in Korea, those older Korean immigrants were also recruited through a senior center, a senior school, and a senior housing complex which all are located in the residential area of this southeastern city. Because all participants were known to be

cognitively intact enough to communicate in Korean, all respondents had no problem in reading and understanding in Korean.

Data Measures

Predictor variables

Socio-demographic variables were collected for this sample. Those included gender, age, educational level, marital status, monthly income, religion, living arrangement, and immigration-related factors (immigration motive, duration, citizenship, and English proficiency level). It is hypothesized that persons who are older, poor, living alone, recent immigrants and without citizenship are more vulnerable to depression than persons who are relatively younger, with adequate living conditions, living with extended family, and immigrants with legal status and English proficiency.

A single question was used to measure perceived *health*. In a previous study, a one item measure of perceived health was found to be correlated positively and significantly with the over-all score of a 20 item health-related quality of life measure with established validity and reliability (Musick, 1996). Older adults were asked if they have currently experienced any health problems among 14 specific conditions on the list. This list included common physical problems among older adults, such as Arthritis/rheumatism, depression, diabetes, high blood pressure, vision/hearing problems, and others. Consistent with the other outcome variables, a higher score on the scale indicates a worse overall perceived health status.

The Instrumental Activities of Daily Living (IADL) Scale tends to evaluate more sophisticated functions than the Activities of Daily Living (ADL) index (Fillenbaum, 1988). The IADL component of the Older Americans Resources and Services (OARS) has been developed as a separate, nine item, self-report assessment tool adapted from the Lawton IADL scale

(Fillenbaum, 1988). Unlike the Lawton IADL Scale, all items are asked of both men and women. This instrument has been used as a screening tool to determine the need for further assessment in older adults and for resource allocation (Kane & Kane, 2000). The IADL included nine areas in older adults' daily lives such as using the phone, meal preparation, doing laundry, shopping, house maintenance, self-medication, and managing money. The first answer measures independence; the second, capability with assistance; and the third, dependence (Fillenbaum, 1988). This instrument was known to have an acceptable test-retest reliability of .71 and have relatively higher correlations with physical health (.54 - .55) and mental health (.54 - .60) (Kane & Kane, 2000). A higher total score on the scale indicates a less independent status.

The Acculturation Level Scale developed by the author assesses the extent of Korean immigrant older adults' acculturation into American culture. By reviewing recent representative studies about ethnic older adults (e.g., Burr & Mutchler, 2003; Casado & Leung, 2001; Chiriboga, Black, Aranda, & Markides, 2002), the author selected several items seemingly the most relevant to older immigrant population. Those recent studies mainly focused on English language skills and/or length of residence in the U.S. as indicators of acculturation level. In addition to those two items, the author added two items such as immigration motives and U.S. citizenship status. The author categorized the active (self-initiative) and passive (follower or invitees by others) immigrants based on the immigration motive and whether people are holding U.S. citizenship or permanent residency or live under an illegal situations. The English proficiency is measured by a 5-point likert type question ranging from perfectly fluent to unable to speak. Thus, the author hypothesized that the self-initiative immigrants rather than followers or invitees have a deeper level of acculturation, and persons having US citizenship live more stable than non-citizen, and possessing English proficiency indicate a higher level of

acculturation. Because the author first developed this scale, this scale's reliability and validity will be reported later.

Mediating variables

The Multidimensional Scale of Perceived Social Support (MSPSS) is used to measure perceived social support among older adults (Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS is a 12-item instrument designed to measure perceived social support from three sources: family, friends, and a significant other. The MSPSS assesses the extent to which respondents perceive social support from each of those sources and is divided into three subscales: family (4 items), friends (4 items), and significant other (4 items). The MSPSS is easily scored by adding individual item scores for the total and subscale scores then divided by the number of items. Higher scores reflect higher perceived support. The MSPSS has good factorial validity and has good concurrent validity, correlating with depression (Zimet et al., 1988)

The Religious Involvement Scale is used to measure levels of intrinsic and extrinsic religiosity, which were adapted from Chatters and colleagues' (1992) analysis of data from the National Survey of Black Americans. The Organized Religious Scale was used to measure extrinsic religiosity and the Non-Organized and Subjective Religiosity scale was used to measure intrinsic religiosity. The items in these scales corresponded with the definitions of extrinsic and intrinsic religiosity used for this study. In Chatters and colleagues' (1992) study and in a separate study by Krause and Van Tran (1989) that examined religiosity and stress while also using a sample from the National Survey of Black Americans, the factor model was generated by acceptably described a relationship between the variables attributed to the subscales (Kolomer, 2001).

Expectation of Filial Responsibility (EFR) Scale was initially developed by Seelbach (1977, 1978) to measure the level of filial aid received from adult children by an aged parent. The author used only 6 items to measure how much Korean older adults expect filial obligation from their own children. The author revised the 3-point Likert-type scale to a 5-point Likert-type scale. Higher total scores indicate higher expectations of filial obligation. While the original article did not report the reliability of this scale, some indirect concurrent validity information was available. Scores are significantly associated with sex (females were more likely than males to report high filial support), marital status (widowed or non-married reported higher levels of support than married), income (those with higher income reported less support), and health status (persons in better health reported less support). No racial differences between whites and blacks were found (Seelbach, 1977).

Outcome variable

The Short Version of the Geriatric Depression Scale (GDS-Short) was used to measure depression in the elderly (Yesavage, Brink, Lum, Heersema, Huang, Rose, Adey, & Leireer, 1983). The short GDS was written in simple language and can be administered in an oral or written format. Translations are available in Spanish, Hebrew, Russian, French, Chinese, and Korean. Of the 30 items, 15 items asking for simple yes and no responses were included in the short form. The total GDS score ranges from 0 to 15. A score of 0-5 indicates no depression; a score of 5-10 indicates mild depression, and a score of 10 and above indicates severe depression. The GDS in English had excellent internal consistency with an alpha of .94 and it also had good known group validity in distinguishing significantly among respondents classified as normal, mildly depressed, and severely depressed (Yesavage et al., 1983). A recent study using a short

form in the Korean version was known to have good reliability (.85) (Jang, Haley, Small, & Reynolds, 2000).

Data Analyses

The analysis was carried out in four steps. First, after presenting the means and percentages of socio-demographic variables, the non-parametric t-test for two independent samples and analysis of variance (ANOVA) was performed in order to address group differences among two separate samples' characteristics (Table 2, 3, & 4). Second, the correlation matrix among the major variables was presented and used for next path analysis (Table 5 & 7). Third, as an extension of multiple regression, path analysis was used to test two competing path models with causal orders among a set of variables (Table 8 & 9). Finally, the goodness of fit summary was presented whether hypothesized model is fit (Table 7).

Path analysis can be viewed as an extension of multiple regression. However, in a path analysis, there is more than one dependent variable and it addresses with the predictive ordering of variables. Hence, path analysis has an advantage in allowing a researcher to test a theory of causal order among a set of variables (Kline, 1998; Grimm & Yarnold, 1994). The path model is usually presented both in words and by path diagrams (see Figure 2) which can be viewed as a compact statement of a set of hypotheses. Explicitness (required to lay out a model) and compactness (achieved by the conventions of a path diagram) are two of the characteristics that make path analysis so attractive (Grimm & Yarnold, 1994).

There are two major kinds of results (Joreskog & Sorbom, 1993; Kline, 1998). First, a path analysis provides estimates of the magnitude of the hypothesized effects. It is important to appreciate that the estimates obtained are conditional on the model being correct. Second, a path analysis usually allows one to test that the model is consistent with the observed data. If the

model is not consistent with the observed data, one can reject the model as being very unlikely. As this study basically seeks to examine the effects of social supports and religiosity as mediators on mental health outcome, the path model will be useful to present all kinds of effects (direct, indirect, and total effects) among major variables.

The goodness of fit statistics used in the present study to assess model fit are as follows: (1) Chi-square (χ^2) and degree of freedom (df), (2) the Goodness-of-Fit Index (GFI), (3) the Comparative Fit Index (CFI), (4) the Non-Normed Fit Index (NNFI), (5) the Root Mean Square Error of Approximation (RMSEA) which all fit measures that are well explained in the most cited textbooks (Kline, 1998). Chi-square (χ^2) as the traditional absolute fit measure is used to test the closeness of fit between the hypothesized model and the perfect fit (Kline, 1998). A smaller χ^2 value is indicative of good fit, whereas a large value reflects poor fit. As with the GFI, values of CFI range from zero to 1.00, with values closer to 1.00 indicative of good fit, and .90 is the 'critical value' that indicates acceptable fit (Hoyle & Panter, 1995). Similar to the CFI, the NNFI compares how much better the model fits compared to a baseline model (Hoyle & Panter, 1995; Kline, 1998). Finally, by taking into account the error of approximation in the population, the RMSEA' values less than .05 indicate good fit, values as high as .08 represent reasonable errors of approximation in the population, and values above .10 indicate mediocre fit (Joreskog & Sorbom, 1993). Because different indices reflect different aspects of model fit, researchers typically report the values of multiple indices as mentioned above.

The following chapter will provide the data results obtained from the statistical analyses mentioned above throughout descriptive statistics, one-way analysis of variance, bivariate correlation, and path analysis. The data results will include sample characteristics with non-

parametric t-test and then answer to three research questions and specifically five hypotheses by performing a series of statistical testing.

CHAPTER 4

RESULTS

Sample Characteristics

The statistical analyses for this research were conducted using version 11.0 of the Statistical Package for the Social Sciences (SPSS) and version 8.52 of LISREL. Descriptive statistics were used to summarize several ordinal demographic variables and major continuous variables. Independent sample t-tests (non-parametric tests and mean difference tests) were used to distinguish the groups' differences, depending on the level of measurement of the variables of interest. The results of these tests demonstrated the rationale for separate data analyses for each group. The total sample (N= 449) included 246 Korean older adults (54.8% of the sample) and 203 Korean-American older adults (45.2% of the sample).

Socio-demographic variables

Several major socio-demographic variables were identified in this analysis (See Table 2). The non-parametric independent 2-sample t-test (Mann-Whitney U test) revealed no significant differences between the two groups on the variables of gender, education and monthly income. Women were the majority in both groups (n = 55; 64% of the Koreans versus n = 140; 69% of the Korean-Americans). Majorities in each group also had less than twelve years of education (n = 155; 63% of the Koreans and n = 122; 60% of the Korean-Americans). A majority in each group also had income of less than \$1,000 per month (n = 161; 65% and n= 137; 67%, respectively). In terms of socio-economic status (SES), these findings indicate that more than half of respondents were women, earning less than \$1,000 per month, and that most of the respondents had little formal education.

However, both of the groups were found to be significantly different in terms of other socio-demographic variables. The Korean-American group ($M = 72.04$, $SD = 6.52$) with a range from 60 to 88 years was significantly older than the Korean sample ($M = 70.29$, $SD = 7.40$) with a range from 58 to 93 years. Since the Korean group was more likely to be married than their Korean-American counterparts ($n = 175$; 71% versus $n = 124$; 61%, respectively), the proportion of Korean-Americans living alone or only with their spouse was 56.1% ($n=114$), compared with 36.2% ($n=89$) of the Korean sample. As expected, the percentage of Koreans living with their children or extended family ($n= 157$; 63.8%) was noticeably higher than their Korean-American counterparts ($n= 89$; 43.9%). These data suggest that extended family relationships are more common in the Korean rather than in the Korean-American population. This is also reflected in the fact that the number in households of the Korean sample was larger than that of the Korean-Americans ($M = 3.30$, $SD = 1.63$ vs. $M = 2.78$, $SD = 1.76$).

There were statistically significant differences in terms of employment, residence, and religion between two groups. This study showed that older Koreans ($n=75$; 30.5%) were more likely to be employed than older Korean-Americans ($n=26$; 12.8%). This finding could reflect the likelihood that older Korean-Americans might experience employment barriers in the United States because of their lack of familiarity with American language and culture. Of particular interest was the finding that whereas Korean-American elders ($n=62$; 30.5%) tended to live more frequently in senior housing complexes, only two Korean respondents lived in this type of residence. In contrast, almost all older Koreans (99.2%) were more likely to live in private homes ($n=143$; 58.1%), in apartments or condominiums ($n=101$; 41.1%). Analyses of religion revealed that 74% of the Korean-Americans were Protestant ($n = 150$) and less than 10% ($n= 19$) were non-Christian. In contrast, although almost 58% of Korean respondents were involved with

Christianity comprising of 45.5% of Protestants (n =112) and 12.6% of Catholic (n=31), 42% of this sample also reported to affiliate with either Buddhism (n = 77; 31.3%), Confucianism, or no organized religions (n=26; 10.6%).

Table 2

Sample Characteristics (N = 449)

Variable		Korean (n=246) N (%)	Korean-American (n = 203) N (%)
**Age	Mean (SD)	70.29 (7.29)	72.04 (6.52)
Gender	Female	155 (63.0)	140 (69.0)
Education	Below 12 th grade	155 (63.0)	122 (60.1)
Income	Below \$1000/month	161 (65.4)	137 (67.5)
** Marital status			
	Married	175 (71.1)	124 (61.1)
*** No. in Household			
	Mean (SD)	3.30 (1.63)	2.78 (1.76)
*** Employment			
	Employed (FT/PT)	75 (30.5)	26 (12.8)
*** Living arrangements			
	Living alone	31 (12.6)	52 (25.6)
	Living with spouse	58 (23.6)	62 (30.5)
	Living with children	115 (46.7)	60 (29.6)
	Living with extended family	42 (17.1)	29 (14.3)
*** Residence			
	Private home	143 (58.1)	90 (44.3)
	Apartment/condominium	101 (41.1)	51 (25.1)
	Senior housing complex	2 (.8)	62 (30.5)
*** Religion			
	Protestant	112 (45.5)	150 (73.9)
	Catholic	31 (12.6)	34 (16.7)
	Buddhism	77 (31.3)	10 (4.9)
	Other	26 (10.6)	9 (4.4)

* p <.05 ** p <.01 *** p < .001

Physical health variables

Physical health status was measured with three different scales that measured self-rated health status ranging from 1 (excellent) to 4 (poor), 14 health indicators, and instrumental activities of daily living (IADL) (Kane & Kane, 2000). The results are shown in Table 3. First, there was a significant difference in that the Korean elders tended to rate their physical health as poorer than that of the Korean-Americans. While only 21% (n=51) of the Korean sample rated their health condition to be excellent or good, 30% (n=59) of the Korean-American sample rated themselves at this level. More than 70% in both groups rated their physical health as fair to poor ($M = 3.07$, $SD = .80$ vs. $M = 2.90$, $SD = .89$). Although there was no difference in 14 health indicators that included high blood pressure, back problems, diabetes, vision and hearing problems, when self-rated health status was combined with these 14 health indicators, results confirmed the statistically significant difference in that the Koreans ($M=5.71$, $SD=2.63$) were in poorer health than the Korean Americans ($M=5.24$; $SD=1.60$). Arthritis and high blood pressure were the two most frequently reported physical problems among both samples. While 45.9% of the Korean sample (n=113) reported arthritis or rheumatism, 45.3% of the Korean-Americans (n=92) reported high blood pressure. With no statistical difference in functional abilities, majorities in both samples reported to have highly independent functional capacities in IADL (Koreans: $M = 24.78$, $SD = 3.04$; Korean-Americans: $M = 24.70$, $SD = 3.25$).

Psychosocial variables

The psychosocial status of both groups was measured using scales that concentrated on social support, religiosity and depression. Social support and religiosity were identified as coping variables and depression as an outcome variable for purposes of advanced data analysis in this study.

Table 3

Group Comparisons of Major Variables

Variables	Range	Koreans	Korean Americans
		<i>M (SD)</i>	<i>M (SD)</i>
<u>Physical health status</u>	1 - 18	5.71 (2.57)	5.24 (2.15)
*Self-rated health status	1- 4	3.07 (.80)	2.90 (.89)
Excellent		9 (3.7%)	16 (7.9%)
Good		42 (11.1%)	43 (21.2%)
Fair		117 (47.6%)	90 (44.3%)
Poor		78 (31.7%)	54 (26.6%)
14 health indicators	0 – 14	2.63 (2.09)	2.34 (1.60)
Arthritis		113 (45.9%)	77 (37.9%)
High blood pressure		90 (36.6%)	92 (45.3%)
Depression		42 (17.1%)	19 (8.9%)
Functional ability (IADL)	9 - 27	24.78 (3.04)	24.70 (3.25)
<u>Psychosocial status</u>			
Social support (MPSS)	12 – 60	45.21 (9.19)	46.24 (8.46)
**Family	4 - 20	16.13 (3.58)	17.13 (3.07)
Friends	4 – 20	13.45 (4.11)	13.34 (3.80)
Significant others	4 – 20	15.63 (3.38)	15.77 (3.56)
***Religiosity (REL)	9 - 52	31.86 (12.77)	37.10 (9.14)
***Extrinsic	2 - 16	10.08 (4.70)	11.72 (3.53)
***Intrinsic	7 - 36	21.78 (8.56)	25.38 (6.42)
***Depression (GDS-S)	0 – 15	6.21 (3.90)	5.00 (3.25)

* $p < .05$ ** $p < .01$ *** $p < .001$

Social support. While both groups showed no difference in total scores on the social support scales (Zimet et al., 1988), on the three subscales (family, friends, and significant others), the Korean-Americans reported more support from family members than Koreans living in Korea ($M=17.13$ $SD=3.07$ versus $M=16.13$ $SD=3.58$). The total scores on the subscale measuring support from friends were relatively lower than the scores on the two other subscales ($M=13.45$, $SD=3.58$ in Koreans; $M=13.34$, $SD=3.80$ in Korean-Americans), but there was no statistically significant difference between the groups. The scores on the subscales measuring support received from significant others were not statistically significant ($M=15.63$, $SD=3.38$ for the Koreans and $M=15.77$, $SD=3.56$ for the Korean-Americans). For purpose of this study, significant others included spouses, confidants, adult children, God, mentors or another special person.

Religiosity. Religiosity was measured using two subscales that explored both intrinsic and extrinsic religiosity (Chatters, Levin, & Taylor, 1992). There were significant differences between two groups. Korean-American elders reported higher total scores ($M=37.10$, $SD=10.10$) than Korean elders ($M=31.86$, $SD=12.77$) in both areas (Table 3).

Depression. The short form of the Geriatric Depression Scale (GDS-S) was used to measure respondents' levels of depression (Pang, 1995; Yesavage et al., 1983). Contrary to this study's expectations that older Korean Americans would be more depressed than older Koreans, group differences were statistically significant in this area. Korean older adults ($M = 6.21$, $SD = 3.90$) reported greater levels of depression than Korean-American older adults ($M = 5.00$, $SD = 3.25$). With a clinical cut-off score of 6.0, 46.3% of Korean elders could be diagnosed as either mildly ($n= 94$, 38%; $M = 6 - 10$) or seriously depressed ($n=38$, 15%; $M =11-15$). In cross-tabulating nationality and gender, while older Korean-American men ($M = 4.51$, $SD = 3.18$) were

found to have the lowest level of depressive symptoms, older Korean women ($M = 6.69$, $SD = 3.92$) were found to have relatively high depressive symptoms. These findings revealed that these Korean elders were significantly more depressed than the Korean-American elders, and that the older Korean women had the highest levels of depressive symptoms among all the groups. From 14 health indicators, it was also found that 17% of the Koreans ($n=42$) and 9% of the Korean-Americans ($n=19$) reported to have depressive symptoms. Those results demonstrate significant discrepancies between self-reported depression and standard measured depression.

Table 4

Cross-tabulation of the GDS score: Nationality * Gender * Diagnosis Level

Depression Level	Nationality	Gender		Total	Percentage
		Male	Female		
Not depressed (0-5)	Koreans	47	57	114	46%
	Korean Americans	43	85	128	63%
	Total	90	152	242	54%
	Percentage	58%	52%		
Mildly depressed (6-10)	Koreans	35	59	94	38%
	Korean Americans	18	46	64	32%
	Total	53	105	158	35%
	Percentage	34%	36%		
Seriously depressed (11-15)	Koreans	9	29	38	15%
	Korean Americans	2	9	11	4%
	Total	11	38	49	11%
	Percentage	7%	13%		

Immigration variables

As discussed in the stress-coping model, immigration status (length of residence in the United States, immigration motives, citizenship status, and English language proficiency) was identified as a major stressor for the Korean-American sample. The average length of time elapsed since immigration was 14.60 years ($SD=8.65$). Most of the Korean-American immigrants ($n=169$; 83.2%) either accompanied their children to the United States or were invited to

America by family already living there. It is an important finding that only 13.3% of this sample ($n=27$) reported initiating their immigration by themselves, that is, without help from family.

While the percentage of the Korean-Americans having American citizenship was only 43.3% ($n=88$), almost half respondents reported being permanent residents ($n=95$, 46.7%). This finding was interesting since more than 71% of the Korean-American elderly sample ($n=144$) reported difficulty in speaking English. This data revealed that inadequate language proficiency is related to limited education and a shorter duration in the United States. Therefore, language barriers may limit the opportunities for Korean-American elders to fully enjoy the benefits of their American citizenship.

A one-way analysis of variance (ANOVA) was conducted to examine the effects of immigration on the mental health of the Korean-American elders. This analysis revealed that while the motives for immigration ($F = 3.57, p < .015$) and language proficiency ($F = 4.11, p < .015$) were statistically significant variables in relation to levels of depression and language proficiency, the amount of time elapsed since immigration and citizenship status did not significantly predict depression.

Bivariate Correlation Analysis

Bivariate correlation shows either a positive or negative correlation direction among chosen variables and also illuminates the magnitude of the relationship among variables. All variables have been converted into continuous variables for purposes of analysis using the PRELIS program. The PRELIS program will produce either covariance or correlation matrix, and will be imported to the LISREL program for path analysis. Accordingly, the bivariate correlation matrix with raw data is used to undergird the theoretical model in emphasizing the causal order rather than the linear relationships among variables. While the reliabilities for most

Table 5

Effects of Immigration Factors on Depression Among Korean–Americans ($n = 203$)

Variables	N (%)	F	Sig.
U.S. Duration (Years)			
Mean (SD)	14.60 (8.65)	.630	.938
Immigration Motives		3.573	.015
Self-initiated	27 (13.3)		
Invited by Children	61 (30.0)		
Invited by other relatives	108 (53.2)		
Other	7 (3.4)		
Citizenship		1.839	.141
U.S. Citizenship	88 (43.3)		
Permanent Resident	95 (46.8)		
Temporary visitor	18 (8.9)		
Other	2 (1.0)		
English Proficiency		4.111	.003
Excellent	7 (3.4)		
Good	8 (3.9)		
Fair	44 (21.7)		
Poor	93 (45.8)		
None	51 (25.1)		

of the scales were known, the reliability of the SDS and health scales was estimated to be .85.

Tables 7 & 8 show the correlation results along with means, standard deviations, kurtosis and skewness that would be basic data for estimating the path analysis. At the bivariate level, some differences emerged between the Korean and Korean-American groups.

Korean model

The SDS factors were modestly significantly correlated with health ($\gamma = -.168, p < .01$), social support ($\gamma = .168, p < .01$), and depression ($\gamma = -.254, p < .001$). This finding demonstrated that people with better social-economic status would report better health, have more satisfactorily perceived social support and feel less depressed. However, SDS is not correlated with IADL and religiosity. Physical health status was strongly significantly correlated with IADL ($\gamma = -.353, p < .001$), social support ($\gamma = -.228, p < .001$), and depression ($\gamma = .396, p < .001$). This means that people in better health are more likely to be independent in their activities of daily living, to have more social support, and to feel less depressed. Social support is significantly correlated with SDS ($\gamma = .168, p < .01$), health status ($\gamma = -.228, p < .001$), IADL ($\gamma = .146, p < .05$), and depression ($\gamma = -.203, p < .001$), but is not significantly correlated with religiosity ($\gamma = .032, ns$). None of the listed variables is significantly correlated with religiosity in this group. Depression is statistically significantly correlated with SES ($\gamma = -.254, p < .001$), health status ($\gamma = .396, p < .001$), IADL ($\gamma = -.299, p < .001$), and social support ($\gamma = -.203, p < .01$). This indicates that higher levels of depression can be related to lower SES, poor health, lower functional ability, and fewer social supports.

Korean-American Model

SDS was significantly correlated with social support ($\gamma = .200, p < .01$) and depression ($\gamma = -.185, p < .05$), indicating that people with higher SDS would be likely to have more social support and feel less depressed. Physical health was significantly associated with IADL ($\gamma = -.304, p < .001$) and depression ($\gamma = .354, p < .001$). These findings indicate that respondents who reported better physical health were more likely to live independently and report less depression.

Table 6

Zero-Order Correlations Between Study Variables for the Korean Model (n=246)

Variables	1	2	3	4	5	6
1. SDS		-.168**	.037	.168**	.018	-.254***
2. Health			-.353***	-.228***	.080	.396***
3. IADL				.146*	.010	-.299***
4. Social Support					.032	-.203***
5. Religiosity						-.053
6. Depression						
Mean	9.06	5.71	24.78	45.21	31.86	6.21
S.D	2.92	2.57	3.04	9.19	12.77	3.90
Kurtosis	-.674	-.396	5.40	-.850	-.927	-.809
Skewness	-.003	-.387	-2.14	.060	-.560	.326
Reliability	.85	.85	.86	.90	.91	.82

* P < .05 ** P < .01 *** P < .001

Social support was significantly related to SDS, religiosity ($\gamma = -.203$, $p < .01$) and depression ($\gamma = -.345$, $p < .001$). This result demonstrates that people with more social support are more likely to report better socio-economic status, lower religiosity and less depression. Religiosity was negatively correlated with social support ($\gamma = -.203$, $p < .01$) and depression ($\gamma = -.165$, $p < .05$). It is of particular interest that people with stronger religiosity were more likely to report less social support and less depression. SDS, physical health, IADL, social support, and religiosity were all significantly associated with depression.

Summary

At the bivariate level, some differences emerged between Korean and Korean-American elders in the correlational patterns among the study variables (Table 7 & 8). For both groups, self-rated physical health is the most salient predictor of depression ($\gamma = .396$ for Korean elderly, $\gamma = .354$ for Korean-American elderly). While social support is also statistically significantly associated with depression in both groups, religiosity is significantly related to depression only in the Korean-American group. Particularly among Korean-Americans, religiosity is also negatively significantly related to social support and depression.

Path Analyses

Whereas correlation concerns association and directionality, regression concentrates on prediction. None of the correlation and regression analyses could help to explain the causality based on this study's theoretical framework. The path analysis is used to examine a plausible causal relationship using both observed correlations as well as the influence of covariates (Joreskog & Sorbom, 1993; Kline, 1998). In addition, while regression analyses reveal only direct effects of predictor variables on outcome variables, path analysis coefficients make it possible to calculate estimates of the indirect, direct, and total effects. As discussed in Chapter 2, it is hypothesized that social support and religiosity as major coping variables could act as moderators against depression. In this sense, the indirect effects of coping variables can be calculated in path analysis. The total effects are the sum of all the direct and indirect effects of one variable on another.

Before analyzing the data for multiple group path models, missing values for both data were deleted using the listwise deletion method. The data were tested for univariate and

Table 7

Zero-Order Correlations between study variables for the Korean-American Model (n = 203)

Variables	1	2	3	4	5	6
1. SDS		-.074	.048	.200**	.098	-.185**
2. Health			-.304***	-.121	.014	.354***
3. IADL				.118	-.003	-.268***
4. Social support					-.203**	-.345***
5. Religiosity						-.165*
6. Depression						
Mean	8.33	5.24	24.70	46.24	37.10	5.00
S.D	3.23	2.15	2.35	8.43	9.14	3.25
Kurtosis	-1.01	-.285	11.07	-.045	.924	-.309
Skewness	.309	.116	-2.60	-.435	-1.05	.650
Reliability	.85	.85	.76	.87	.85	.75

* P < .05 ** P < .01 *** P < .001

multivariate normality, as well as for significant outliers using the DeCarlo test. Tables 7 and 8 present the means, standard deviations, skewness, kurtosis and reliability for each of the continuous variables of both groups. With the exception of functional ability (IADL), the total scores for each variable showed univariate normality as their skewness and kurtosis values did not exceed an absolute value of |2.0|. However, the IADL variables were noticeably skewed (-2.14 vs. -2.60) and kurtotic (5.40 vs. 11.07). Although the IADL variables were not normally

distributed, they were necessarily included as an additional explanatory stressor that helped elucidate the stress-coping model.

Because the distribution of one variable (IADL) was non-normal, the Satorra-Bentler Scaled Chi-Square statistic with Maximum Likelihood (ML) estimation method was used in order to adjust for the non-normality of the sample data. According to Chou and Bentler (1995), the Satorra-Bentler Scaled Chi-Square is more accurate than the Chi-Square based on Distribution-free (ADF) estimations and robust standard errors are also more accurate when the sample size is small to moderate.

Table 8

Goodness of Fit Summary

Models	Satorra-Bentler χ^2	df	RMSEA	NFI	CFI	GFI
1. Korean Model	2.80	1	.025	.98	.98	1.00
2. Korean-American Model	1.37	1	.016	.99	1.00	1.00

One of this study's main interests was to ascertain whether the structural paths in this model were the same for Korean older adults versus Korean-American older adults. Therefore, multiple group path analyses were used to test the hypothesized relations among the study variables using the statistical package LISREL 8.52 for Windows (Jöreskog & Sörbom, 1993a). One application of multiple-group analyses is to provide a statistical test of whether the sample paths and path values hold for more than one group or whether separate models are needed for different groups (Bollen, 1989). These analyses also allow the researcher to determine exactly which paths are invariant across groups and which have essentially the same values in both

groups. Separate covariance matrices for Korean older adults and Korean-American older adults were generated by the PRELIS 2.51 program (Jöreskog & Sörbom, 1993) as input to LISREL.

The set of fit indexes and the criteria used to determine the fit of the path model were based on the recommendations of Hu and Bentler (1999). They recommended reporting the SRMR (Standardized Root Mean Residual) or RMSEA (Root Mean Square Error of Approximation) as a stand-alone index that is not based on any type of model comparison. While the SRMR is the most sensitive to simple model misspecification and moderately sensitive to complex model misspecification, the RMSEA is also very sensitive to complex model misspecification as a standardized measure of the lack of fit of the population data to the model. The values of incremental fit indices such as the NFI (Normed Fit Index), CFI (Comparative Fit Index) and GFI (Goodness of Fit Index) were used to compare the difference in fit of the baseline and target models to the difference between the fit of the baseline model and the ideal fit of the target model. A larger value indicates a better fit. The cutoff criteria in this research were .95 or higher for the NFI, CFI, GFI combined with a cutoff value of .08 or less for the SRMR and .06 or less for the RMSEA. Based on the output (Table 9), the RMSEA is much less than .06 and the SRMR is also less than .08, suggesting that the model does provide a good fit to the data. Values of the NFI, CFI, and GFI all suggested a good fit of the model. It is concluded that the Korean-American model provides a better fit than the Korean model in this sample.

Korean Model

As shown in Table 7, goodness-of-fit indexes for the Korean model indicated a plausible fit among the sample of older Koreans (Satorra-Bentler χ^2 (N=246) =2.80, df=1). While the GFI of 1.00 and the NFI and the CFI of all .98 were generally considered indicative of a good fit along with the RMSEA (.025), values of .05 or below indicate a close fit. In the Korean path

Table 9

Parameter Estimates for a Model for the Older Korean Group (n=246)

Path models	Path values	SE	t-values
On Depression			
SDS	-.25	.07	-3.28*
Health	.44	.09	5.04*
IADL	-.23	.07	-3.16*
Social Support	-.12	.06	-2.03*
Religiosity	-.03	.03	-1.13 R² = .24
On Social Support			
SDS	.16	.08	2.02*
Health	-.17	.10	-1.65
IADL	.05	.08	.65 R² = .04
On Religiosity			
SDS	-.06	.20	-.28
Health	.24	.23	1.00
IADL	.11	.18	.58 R² = .005

Critical t-value on the 0.05 significant levels is | 1.96 |

model (Table 8), the four exogenous variables were directly associated with depression. As expected, lower SDS status was related to higher depression ($t = -3.28$). Two major health indicators, poor physical health ($t = 5.04$) and functional ability ($t = -3.16$) were significant predictors of depression. Those results demonstrated that respondents in poorer physical health and lower functional ability are more likely to be depressed.

As a coping factor, social support ($t = -2.03$) was more likely to function as a protector against depression than was religiosity. However, religiosity ($t = -1.13$) was not a statistically significant factor predicting reduced depression among the Korean elders. It was also shown that elders with better SDS tended to receive more social support than people with lower SDS.

Interestingly, although the relationship between social support and health is negatively related, but not enough to be statistically significant, other hypothesized paths between exogenous variables (SDS, health, IADL) and endogenous (social support and religiosity) are not statistically significant.

The R square value is the proportion of variance in the dependent or endogenous variable that is accounted for by the independent or exogenous variables. For the Korean older adults, about 24% of the variance in depression could be accounted for by variability in religiosity, social support, SDS, health and IADL. While about 4% of the variance in social support could be

Table 10

Parameter Estimates for a Model for the Older Korean- American Group (n=203)

Path models	Path values	SE	T-values	
On Depression				
SDS	-.07	.06	-1.12	
Health	.40	.09	4.49*	
IADL	-.27	.08	-3.07*	
Social Support	-.06	.03	-2.02*	
Religiosity	-.31	.13	-4.68*	R² = .27
On Social Support				
SDS	.22	.13	1.67	
Health	.016	.23	.068	
IADL	.047	.20	.024	R² = .01
On Religiosity				
SDS	.24	.07	3.64*	
Health	-.13	.10	-1.41	
IADL	-.10	.10	-1.04	R² = .08

Critical t-value on the 0.05 significant level is | 1.96 |

accounted for by variability in SDS, health, and IADL, only less than 1% of the variance in religiosity could be explained by variability in SDS, health, and IADL.

Korean-American Model

As shown in Table 7, goodness-of-fit indexes for the Korean-American model indicated an excellent fit among the sample of older Korean-Americans (Satorra-Bentler χ^2 (N=203) =1.37, df=1). While the GFI of 1.00 and the NFI of .99 and the CFI of 1.00 were generally considered indicative of an excellent fit along with the RMSEA (.016), values of .05 or below indicate a close fit. In the Korean-American model (Table 9), the four exogenous variables are directly associated with depression. In contrast with the Korean model, lower SDS status was not significantly related to higher depression ($t = -1.12$, ns). As in the Korean model, two major health indicators such as poor physical health ($t = 4.49$) and functional ability ($t = -3.07$) were significant predictors of depression. As in the Korean model, those results confirmed that respondents in poorer physical health and lower functional ability are more likely to be depressed.

Two coping variables of social support ($t = -2.02$) and religiosity ($t = -4.68$) functioned significantly as mechanisms that reduced depression. As reflected in the literature, unlike the Korean group, religiosity among the Korean-Americans ($t = -4.68$) was reported to be the most statistically significant factor that reduced depression. Korean-Americans with higher SDS status were more likely to have strong religiosity ($t = 3.64$). Apart from the SDS-religiosity path, other hypothesized paths between exogenous variables (health, IADL) and endogenous variables (social support and religiosity) were not statistically significant.

The R square value is the proportion of variance in the dependent or endogenous variable that is accounted for by the independent or exogenous variables. For the Korean older adults,

about 27% of the variance in depression could be accounted for by variability in religiosity, social support, SDS, health and IADL. The contributing portions of three exogenous variables to two mediating variables were similar for both groups. While about 1 % of the variance in social support could be accounted for by variability in SDS, health, and IADL, only 8% of the variance in religiosity could be explained by variability in SDS, health, and IADL. As reported in Table 5, the Korean-American model explained the larger amount of variance (36%) than the other two models. It is suggested that the proposed hypothesized model is more applicable to the Korean-American sample rather than to the Korean sample.

Hypothesis Testing

Based on the proposed stress-coping model, six specific hypotheses were tested with several statistical methods including analysis of variance, bivariate correlation, and path model analyses.

Hypothesis # 1: Respondents in better socio-demographic status (SDS) are likely to be less depressed. As one of major stressors for both groups, the combined score of SDS was derived from the variables of marital status, income, education, and living arrangements.

Korean sample: In the bivariate correlation matrix, SDS was significantly negatively related with depression ($r = -.254, p < .001$). In addition, SDS was negatively correlated with health ($r = -.168, p < .01$) and positively correlated with social support ($r = .168, p < .01$). In the path analysis, SDS was a significant predictor of depression ($t = 3.28, p < .05$). This result confirmed that the hypothesis # 1 was true in this sample. In addition, while SDS was significantly related with social support ($t = 2.02, P < .05$), it was not significantly related to religiosity ($t = -.28, ns$).

Korean-American sample: In the bivariate correlation matrix, SDS was significantly negatively related with depression ($r = -.185, p < .01$) and positively correlated with social

support ($r=.200$, $p < .01$). However, in the path analysis, SDS was not a significant predictor of depression ($t=-1.12$, ns). Unlike the Korean sample, the data showed that the SDS factor did not have an effect on reducing depression level in this sample. While SDS was significantly associated with religiosity ($t=3.64$, $p<.05$), it did not correlate with social support ($t=1.67$, ns).

Hypothesis # 2: Respondents in higher acculturation level are likely to be less depressed in Korean-American group. As one of the important stressors for older Korean-Americans, the immigration factors such as duration in the US, immigration motive, citizenship status, and English proficiency are associated with depression. ANOVA tests revealed that immigration motives ($F= 3.573$, $P =.015$) and English proficiency ($F=4.111$, $P=.003$) were significantly associated with depression. Those data confirmed that respondents with self-initiative motive to immigrate to the USA and fluent English skills are less likely to be depressed.

Hypothesis # 3: Respondents in poorer physical health and lower functional ability (IADL) are more likely to be depressed.

Korean sample: In the bivariate correlation matrix, physical health status was significantly correlated with functional ability ($r=-.353$, $p < .001$), negatively associated with social support ($r=-.228$, $p < .001$), and positively correlated with depression ($r= .396$, $p < .001$). Functional ability (IADL) was positively correlated with social support ($r= .146$, $p < .05$) and negatively associated with depression ($r=-.299$, $p < .001$). In path analyses, physical health ($t=5.04$) and functional ability ($t=-3.16$) were significantly associated with depression. In particular, self-reported health status was the most salient predictor for all groups and from all analyses. Accordingly, those data confirmed that the hypothesis is true in this sample.

Korean-American sample: In the bivariate correlation matrix, health status was negatively correlated with functional ability ($r = -.304$) and positively correlated with depression

($r = .354$) which is also significantly negatively correlated with functional ability ($r = -.268$). As in the Korean model, path analysis also revealed that physical health ($t = 4.49$) and functional ability ($t = -3.07$) were significantly associated with depression.

Hypothesis # 4: Respondents with more social support are likely to be less depressed. The combined score was derived from the three sub-scales measuring support from family, friends and significant others. Social support as a major coping mechanism could act as a mediator to reduce depression.

Korean sample: Social support had a significantly negative correlation to depression ($r = -.203$, $p < .000$) at the bivariate level. Social support was significantly associated with depression ($t = -2.03$, $p < .05$) in the path model. As hypothesized, both statistics confirmed that people with more social support are likely to be less depressed in this sample.

Korean American sample: Social support had a significantly negative correlation with depression in the bivariate correlation matrix ($r = -.268$, $p < .000$) and was found to be a significant predictor in the path model ($t = -2.02$). Like in Korean model, those data confirmed that the hypothesis # 4 is still true in this sample.

Hypothesis # 5: Respondents in higher religiosity are likely to be less depressed. The combined score of religiosity was derived from two sub-scales that measured intrinsic and extrinsic religiosity. Religiosity as a major coping resource could act as a mediator against depression.

Korean sample: Religiosity was not significantly correlated with depression ($r = -.053$, ns) in the correlational matrix and was not a significant predictor in a path analysis ($t = 1.13$, ns). Those data showed that the hypothesis is null in this group.

Korean-American sample: In the bivariate correlation matrix, religiosity had a significantly negative correlation with depression ($r = -.165$, $p < .05$). Religiosity was significantly associated with depression in the path analysis ($t = -4.68$). To summarize, comparing the Korean model, the inclusion of the religiosity factor in the proposed hypothesized model resulted in an overall excellent fit in the Korean-American model.

Summary

The purpose of this study was to investigate possible answers to three questions: The first question was: What socio-demographic characteristics distinguish Korean elders living in Korea from their counterparts living in the United States? The second question was: What factors contribute to higher depressive symptoms in both groups? The third question involved testing whether this study's proposed hypothesized model based in stress-coping theory fit well for each group. Four hypotheses arose from the second question concerning depressive symptoms. Statistical analyses examined the viability of these hypotheses.

In terms of socio-demographic variables, there were no significant differences between the two groups in gender, education, and monthly income. Women were the majority in both groups, as were persons with no more than 12 years of formal education, and those who earned less than \$1,000 monthly. However, there were significant differences between the two groups in age, types of living arrangements, number of people residing in the home, and religious practices. Koreans living in Korea were older on the average than the Korean-Americans. They were also more likely to live with their children or extended family and to live with more people in their households than the Korean-American sample. The Korean-Americans were more likely to be unemployed or underemployed and to more frequently reside in senior citizen housing

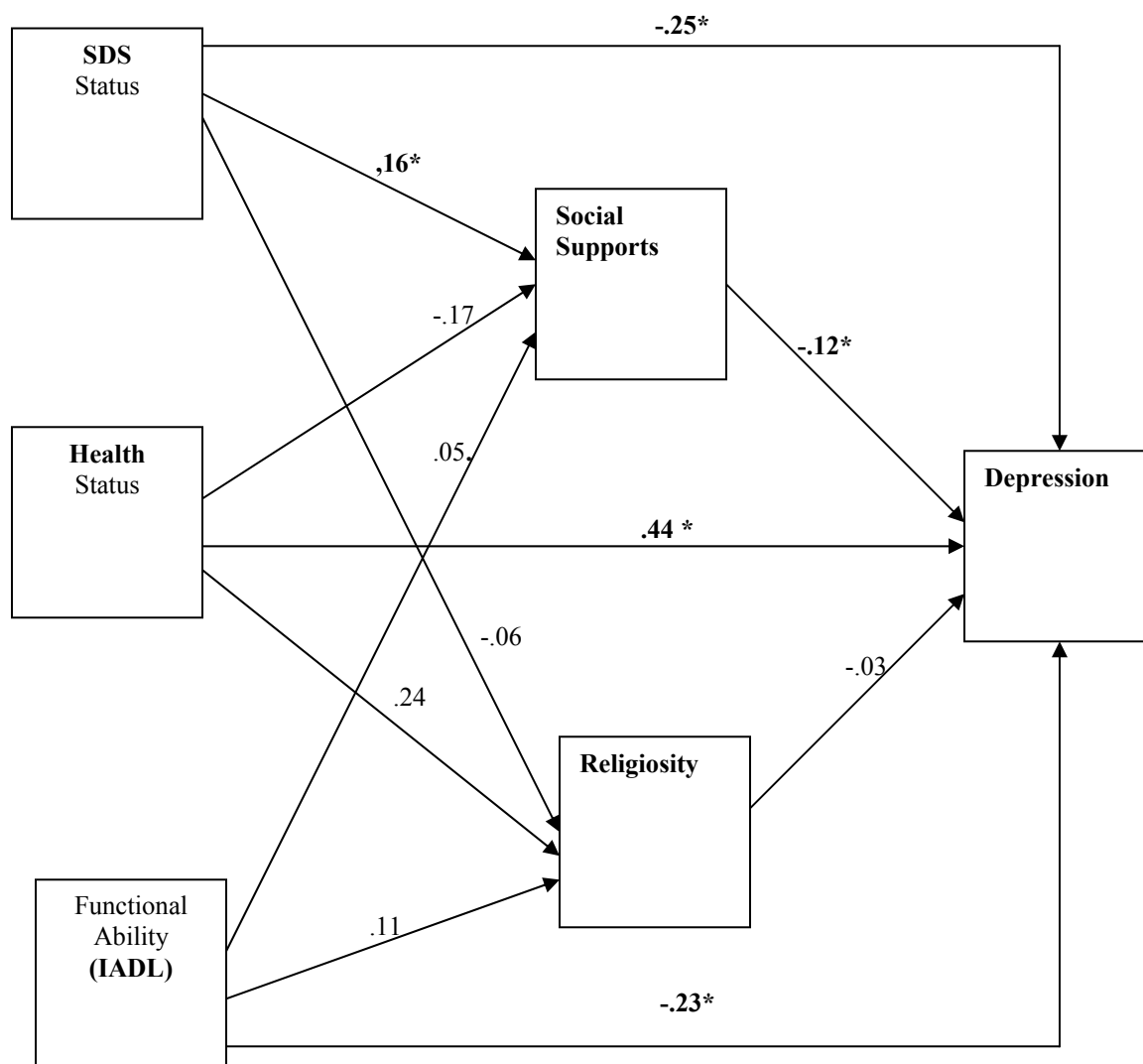


Figure 2. The Korean Model with Path Values

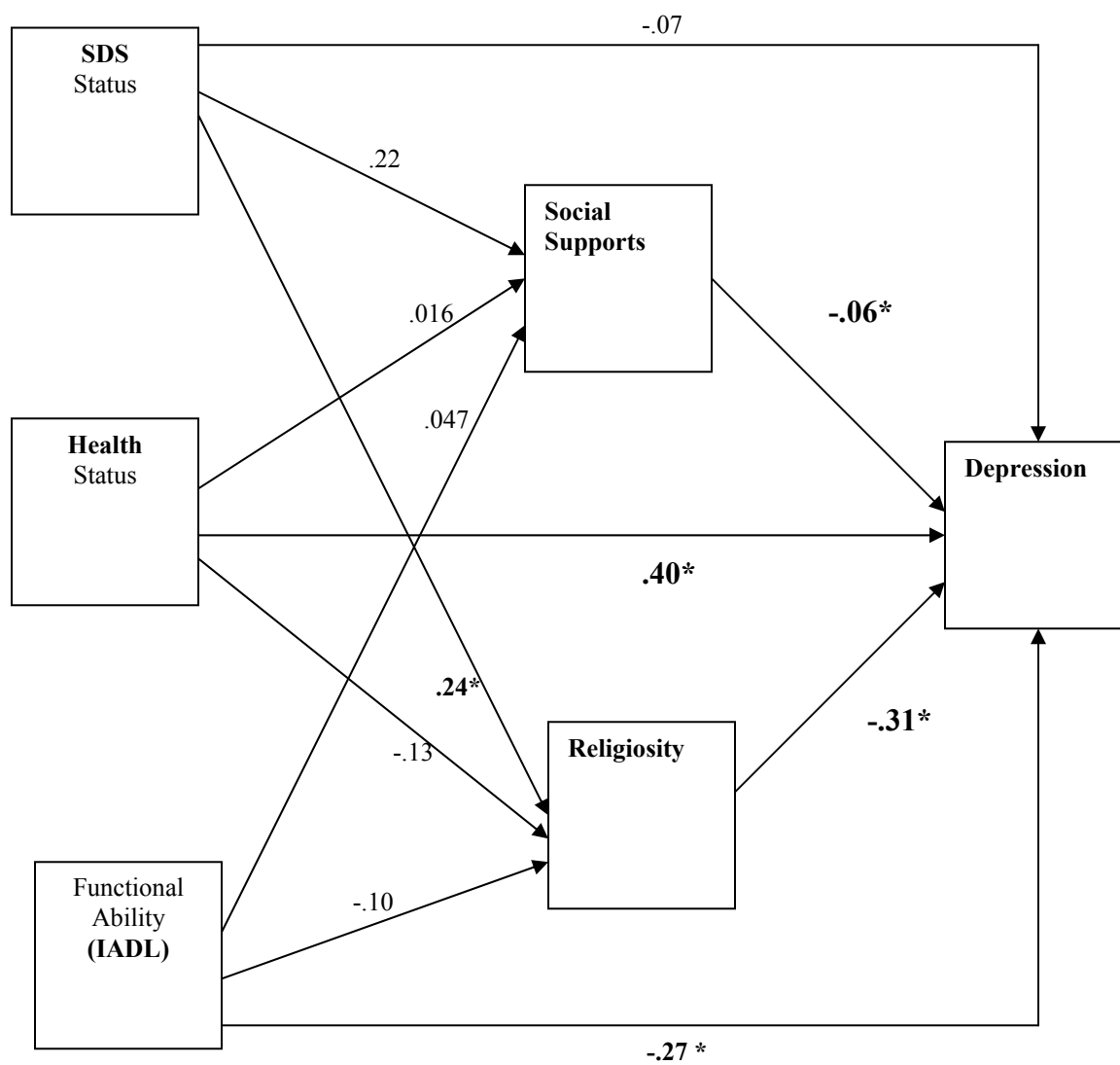


Figure 3. The Korean-American Model with Path Values

complexes. Older Korean-Americans were also more likely to state that they were Christians than their Korean peers.

In terms of physical and psychosocial variables, while almost all participants in both groups were able to live independently, older Koreans tended to rate their physical health as poorer than the Korean-Americans. The older Korean-Americans reported more familial support and a higher degree of religiosity than those living in Korea. An unexpected finding was that older Koreans were significantly more depressed than older Korean-Americans.

Several significant factors predicting higher depression were identified from a series of statistical analyses including Pearson correlations, analyses of variance, and path models. In the Korean American sample, immigration motives and English proficiency were found to be significant correlates of higher depression in the ANOVA test. The proposed hypothesized model provided an overall excellent fit for the Korean-American sample partially due to the inclusion of religiosity. In the path model, both social support and religiosity were significantly associated with depression. For the Korean sample, better social status, good physical health and higher functional ability, and more satisfactory social support predicted lower levels of depression in the model. In contrast with the Korean-American model, while the Koreans' religiosity did not significantly contribute to a reduction in depression levels, social support remained a statistically significant coping variable. As in the Korean-American sample, the overall path model provided a good fit in the Korean sample.

CHAPTER 5

DISCUSSION

The two primary goals of this research were to identify stressors that Korean older adults experience as they age and also to discover the resources that they use to cope with the challenges of later life. Much of this research was organized using the stress process framework. The author thus presented important results based on this framework. This study's results supported existing substantial research that examined relationships between older adults' depressive symptoms and their poor physical health and functional disabilities. This study's results also verified earlier research that demonstrated positive mental health benefits accruing from religious practices for older Korean-American immigrants. The importance of social support was also confirmed for both samples. This study provides a rationale for developing empirically-based social work interventions that can be used with Korean older adults living in Korea and in the United States.

This chapter is divided into four sections. The first section provides in-depth interpretations and explanations of data results presented in Chapter 4. The second section discusses the implications of this research for gerontological social work practice and research in Korea and the United States. The third section addresses this study's limitations. The fourth section proposes directions for future research in this area and provides specific recommendations about the types and locations of social work interventions that will best serve to improve the mental health status of Korean and Korean-American older adults.

Interpretations of Data Results

In this study, the stress and coping model was used to develop the hypothesized model including the relationships among stressors, coping resources, and the mental health outcome among Korean older adults. Therefore, the data results will be briefly illustrated 1) to identify the socially induced stressors and their consequences for mental health, and 2) to examine the effects of social support and religiosity as coping mechanisms on depressive symptoms that both Korean older adults may experience.

In the literature review, four major stressors commonly found in late life were heavily discussed. The potential stressors included socio-economic status, physical health, and functional ability for both older Koreans and Korean Americans. In addition, the immigration status was added as another source of stressor only for older Korean Americans. First, several factors such as lower education, reduced income, and living alone were known to lead average lower social economic status among Korean older population. This study's results also confirmed that being females and single in the SDS were the most critical factors related to poor mental health across two groups. While living arrangements such as living with children or extended family were significant related to better mental health among older Koreans, older Korean-Americans tend to believe that independent living arrangement from adult children is a better option to avoid the possible intergenerational conflict caused by the traditional co-residency.

Among four immigration indicators including length of residence in the U.S., immigration motives, citizenship status, and English language fluency were identified as a major stressor for the Korean-American sample. Among those factors, poor English language skills seem to be related to limited education and a shorter duration in the U.S. Accordingly, language barriers may hinder the chances for Korean-American elders to receive some benefits from their

American citizenship and also limit their social engagement scope to their ethnic communities. Although ethnic communities are beneficial for immigrant older adults, at the same time, those populations tend to be isolated from the larger society and may have very limited access to available psychosocial services and programs.

Third, it is also well known that physical health and functional ability have been critical stressors leading to mortality among older people. Hence, many studies have revealed that subjective rated physical health has robust effects upon well-being such as better mental health. These study data are consistent with previous research where poor physical health and lower functional ability were significantly associated with higher level of depression. However, while most participants reported to have highly independent functional ability in IADL, it is also worthy to notice that lack of public transportation for older Korean Americans might limit their active social engagement which could lead to social isolation and heavy dependency on adult children. Those consequences might cause poorer mental health.

As an effective coping resource, multidimensional effects of social support on depression were examined in the three levels of specific sources – family, friends, and significant others. The data results also concluded that the overall quality of perceived social support has significant impact on the better mental health status. This study also confirmed a selectivity hypothesis to account for changes in later life's social network by revealing that older Koreans tend to interact less frequently with acquaintance and friends, but at the same time, they interact more frequently with spouses and adult children and feel closer emotionally to significant people in their lives. It seems that older adults actively choose to restrict their interactions to the people who really count and they are just as satisfied with their relationships and just as able to count on social support. In other words, although older Koreans' social network might shrink in total size in part

due to limited physical health, functional ability, and/or immigration status, older Koreans still have emotionally rich and supportive relationships with a small circle of intimates.

The human ecosystem theory was also employed as a broad theoretical framework for the current study because it provides a way to view older adults from multiple dimensions and not rely solely on one aspect of an individual to explain or predict behaviors or problems. The important aspect of the ecological model for the current study were older adults' personal socio-demographic characteristics, immigration factors, religious involvement, perceived satisfaction of social supports provided by family, friends, and significant others. In next section, four components from the ecological model will be briefly mentioned along with unexpected findings and their interpretations.

There were several interesting and unexpected findings. Korean-American elders are significantly less employed than Korean elders. This can be explained by the fact that older Korean-Americans experience more difficulty in procuring employment in the United States due to their unfamiliarity with the English language. This hinders their entry into the American labor force. Korean-American elders are more likely to live in senior housing complexes which are unique environments since there are no similar age-restricted housing arrangements in Korea. Korean-Americans reported in this study that they were able to relocate to such senior complexes due to their low income and their American citizenship. Older Korean-Americans residing in a senior housing complex in the Atlanta area found this living arrangement useful in maintaining ethnic identity by participating in community programs geared to their special needs (Kim et al., 2001). As stated previously, ethnic neighborhoods and community as a key component of the mesosystems would play another important function to connect this isolated population with familiar people and resources during their adaptation to the larger society.

As a part of exo-system, the intergenerational relationship in Korean immigrant families seems somewhat more complicated and different from traditional Korean families. Unlike the traditional living arrangements shown in the Korean sample, in which elders live with their children and/or extended family, the option of living in such senior-centered housing complexes may well serve to improve Korean-American elders' quality of life. This choice enables them to live apart from their immediate families and thus provide them with a greater sense of personal independence. It means that many older Korean Americans believe that the co-residence may often lead to intergenerational conflicts, they tend to choose to maintain their family relationships much more flexible and adaptive to American culture.

As a key element of the micro system, the data highlighted the family support as the most vital part of the older Koreans' life. This study also found that older Korean-Americans reported more satisfactory social support than older Koreans. This was an unexpected finding in light of research showing that older Korean immigrants are less satisfied with their lives due to a lack of family support (Kim, 1999; Moon, 1996). A possible interpretation of this finding is that perhaps Korean immigrants more fully appreciate the benefits of familial support than their peers in Korea. Older Koreans often think that aging parents should be unconditionally respected and fully supported by family members. They strongly believe that filial obligations are natural and are to be rendered without question. Thus, older Koreans may not fully appreciate the emotional support they receive from family members. In contrast, older Korean-Americans are fully aware of the many stresses that their children face. Even the most financially secure Korean-Americans continue working to further secure economic stability for both their children and their parents. Hence, older Korean-Americans may lower their expectations of filial obligation. In that sense, older adults' filial responsibility expectations and their family relationships might differ for both

groups because of contrasting social values and expectations. It was also found that both groups perceived less support from their friends than might be expected. Even though older Koreans have broad friendship networks, they may not seek help from these networks, and instead rely heavily on their families to provide emotional support. Since both older Koreans and older Korean-Americans emphasize family harmony, they may be reluctant to seek emotional comfort from friends even when they need advice about family problems. At the same time, older Koreans tend to maintain friendship as a form of reciprocity that may be absent in family relationships.

As mentioned before, it was also found that religious involvement as an important element of the mesosystems was prevalent and also significantly associated with mental health status among older Korean American group. As expected, older Korean-Americans reported active religious practices. Most Korean-American elders regularly attended Sunday services for prayer and to maintain social connections with others. This finding confirmed that Christian church-based activities are very important in the social lives of older immigrant populations living in the southern United States. Sixty-five percent of Korean-Americans are Protestants and approximately 80% of these attend church weekly (Hurh, & Kim, 1990). It is important to understand that churches are the most numerous and most powerful social organizations in the Korean-American community and that Korean American churches meet the spiritual needs of immigrants and provide a variety of social, economic, and psychological resources (Yu, 1990). In contrast, significant numbers of Koreans practice non-Christian religions such as Buddhism (47%) and Confucianism (3%) (CIA, 2003). However, older Koreans who identified themselves as Buddhists have rarely visited the temple due to geographic distance, nor have they read intellectually challenging Buddhist texts. There are no specialized television or radio programs

for Buddhists or members of other religions in Korea. Since the measures used in this study were primarily developed and used in a predominantly Christian cohort, some items in this scale may not be applicable to other non-Christian population cohorts.

Some components in macro systems such as public policy and ideology in the U.S. might have substantial impacts on overall well-being of the older immigrant population. It is significant that many Koreans immigrated to the United States as a result of their children's invitations. It may be that younger Koreans want their elders living nearby only after they have established their own financial security. Since they immigrated in late life, half of the Korean-Americans in this sample did not become American citizens due to their lack of language proficiency and their unfamiliarity with American history and culture. As a result of major changes in United States immigration laws in 1995, it has become more important for Korean immigrants to acquire American citizenship (Binstock, 1998). Holding full American citizenship, as opposed to having only an immigrant green card is particularly crucial for older adults who are in need of continuing health care and other benefits when family support is no longer available. Community social service agencies now frequently educate older Korean immigrants about American history and politics and provide English language instruction to help them in their citizenship application process.

In order to better interpret the mental health data among older Koreans, it is imperative to know about this population's unique background and history. This study also revealed that the mean score of depression was still high for both groups ($M = 6.21$ for the Korean sample; $M = 5.00$ for the Korean-American sample). This result supported earlier studies showing that Korean-Americans have a higher rate of depression among all Asian-American groups (e.g., Kuo, 1984). One explanation for this may be that older Korean-Americans have lived in the

United States for only a short time, without satisfactory employment and with difficulty in adjusting to American society. Thus, it is important for researchers to become familiar with the life experiences of older Koreans in order to better understand why many Korean elders experience serious depressive symptoms (Cho, Nam, & Suh, 1998; Jang Small & Haley, 2001). Older Koreans are the survivors of the pre-World War II Japanese occupation, World War II itself, the Korean War, the geographical division of the nation and its tragic consequences, as well as Korea's rapid modernization and urbanization since 1960. Most Korean elders have lost family and friends, and have been uprooted and have relocated frequently. These life experiences can naturally lead to high rates of depression. The findings of this study support the fact that older Koreans with poorer physical health and less satisfactory social support were more depressed than older Korean-Americans who are actively involved with religious activities and who can rely on more social support.

Implications for Social Work

The results of this study demonstrate the need for more attention by researchers to the particular mental health problems of both older Koreans and Korean-Americans. This section discusses the practice, research and social policy implications of this study's findings. In each section, while discussing such implications for elders in general, the author specifically addresses issues that are particularly relevant to both older Koreans and Korean-Americans.

Practice

First, since the family system is of primary importance in the lives of virtually all aging populations, gerontological social workers should have the skills and knowledge to evaluate this system in its entirety. Comprehensive inter-generational assessment can provide a positive basis for solving family relationship problems. Family conferences that address relational problems

between older adults and their younger relatives are one method by which solutions can be explored. Since older Koreans and Korean-Americans tend to place greater emphasis on their familial roles and derive much personal support and recognition from their positions in their extended families, it is essential that social workers intervene in the lives of these elders use a family systems approach in order to best evaluate and provide suggested solutions for inter-generational problems.

Second, social workers should also be aware of and utilize their clients' internal and external coping skills and resources. Older adults' perceptions of available social support are important since those who have very few social supports may react more negatively to the stresses of late life. Social workers need to understand such personal perceptions in order to better serve their clients. It is also important for practitioners to be familiar with the cultural effects of Confucianism, especially among older Koreans. Korean older adults have historically emphasized strong family values and harmonious interpersonal relationships. As older Koreans expect filial obligations to be appropriately rendered by their children, cross-cultural researchers and clinicians should understand these underlying dynamics that operate within the Korean family.

Third, since religious activity was shown to be an effective coping mechanism for older Korean-Americans, as it is for many older Americans generally, gerontological social workers should evaluate the impact of this dynamic in the lives of their clients. Religious affiliation and practice can be a source of emotional and practical support for older adults and can serve as a means of personal connection with the larger community (Choi & Tirrito, 1999; Yu, 1999). Social workers should explore the degree to which elders' religious beliefs help them interpret and respond to the challenges of the aging process.

Fourth, the influence of ethnicity and culture on aging populations' physical health and psychological well-being is important. The results of this study emphasize the significant contributions of cultural and ethnic sensitivity to gerontological social work practice. Mental health social workers should strive to help older adults achieve levels of health and well-being within their clients' particular cultural and ethnic milieus. Finally, current research findings have important implications for the provision of mental health services not only to older Koreans living in Korea, but also to older Korean immigrants in the United States. Considering that two different groups are situated in different geographical region and influenced by distinguished cultural and societal values, social workers need to gain unique knowledge and skills about two different populations in terms of aging and mental health issues.

Practice with older Koreans

When working with older Koreans in mental health settings, there are several factors social work practitioners should consider. First, it is essential to know that the Korean family is the most important source of social support for older Koreans and that this system is grounded in the concept of filial piety. Filial piety refers to the obligation of family members to care for each other, and the particular obligation for the younger generation to care for the older generation. Adult children must ensure that parents are well cared for in older age. The family often feels great shame if they cannot provide such care. In a health care context, for example, decisions about placing an elderly family member in a nursing home may be somewhat simplified by the cultural norm that expects elderly relatives to be cared for at home until their death. On the other hand, this norm can cause conflict in families that are unable to arrange schedules, finances, and assistance to provide home-based care. Thus, social work practitioners need to understand the

importance of such norms and how these norms can adversely affect inter-generational relationships in Korean and Korean-American households.

Although strong filial expectations still persist among older Koreans, changes in family values in combination with an increased emphasis on individuality may weaken the idea of filial piety and thus remove a source of support that older Koreans have come to naturally expect. In this study, a fair number of the elderly reported inadequate support and loneliness even while living with their children. Social work practitioners can respond to this problem and can provide important interventions via brief family therapy when appropriate. Social workers in these settings should be aware of the mechanisms by which important family decisions are made. Korean families often assign such decisions to the oldest son and his spouse, in contrast to the American norm that emphasizes autonomous decision making.

In Korea, social work practitioners must be ready to challenge long-rooted cultural obstacles in order to build effective clinical relationships. One such obstacle is rooted in the public's perception that only the poor, the disabled, and the mentally ill are the practitioner's clients. Another barrier stems from the reaction to the use of psychotherapeutic services in Korea, a society that often stigmatizes persons receiving such assistance. Most Koreans are unaware of the relatively few psychotherapeutic resources that do exist, and it is commonly difficult for older Koreans to establish therapeutic relationships with mental health professionals precisely because of this stigma (Cho, Nam, & Suh, 1998). Koreans rely on themselves for their emotional sustenance. Occasionally they seek the help of supernatural powers. Most older Koreans simply cannot understand how social workers might be able to help them. Emotional and mental problems are often attributed to heredity or punishment for past behavior. Consequently, the existence of such problems is often denied and the affected individual is

prevented from seeking professional assistance. The family can conceivably “lose face” by virtue of having one of its members seek professional help. Korean families may keep their private concerns to themselves rather than talking about them with “outsiders.” Social workers thus must confront this cultural dynamic respectfully but firmly in order to ensure that persons who need their professional assistance receive it.

When working with older Koreans and their families, social work practitioners also need to understand Korean interpersonal communication. Many important issues would not be discussed directly even among family members. For example, it would be considered improper for a son or daughter to discuss issues related to dying and death with his or her older parents. Older Koreans may be particularly uncomfortable about disclosing personal information out of concern about who will have access to it. Social workers should assure older adults that identifying and processing feelings is not an easy process and explain what the helping process entails by valuing and utilizing older adults’ life experiences. Although some reasons for the high incidence of depression among Korean elders were briefly mentioned earlier, older Koreans who went through such emotional and physical turmoil and economic hardships also learned to rely only upon themselves for survival. It is thus invaluable to understand that older Koreans have already demonstrated resiliency in the face of adversity. This resiliency may now be rediscovered and utilized to improve their quality of life with appropriate therapeutic and social support.

In summary, the Korean society needs to continue to reinforce self-care strategies and the importance of strong family ties for its older population. At the same time, many publicly funded professional social services are needed to augment and perhaps replace some of the traditional Korean methods of coping with personal and family problems. One important issue will be to

alleviate the burden of caring for elderly members of Korean families by their children. The emotional strain of caring for older relatives and the tendency to avoid the use of outside services contribute to this burden. Mental health professionals must pay particular attention to the unattached and isolated elderly who have no family and who have little or no informal support. These individuals are at high risk for institutional placement and neglect because of their social isolation. Since these persons are those least likely to take advantage of formal services, welfare agencies must reach out to them and provide the services they require in order to enjoy a better quality of life.

Practice with older Korean-Americans

The findings in this study demonstrated that there is a need for an expansion in the number of programs and services that can help older Korean-Americans as they adjust to life in the United States. This study revealed that older Korean Americans function within a complex social system that can effectively help or hinder their ability to maintain a high quality of life and independent functioning. This section focuses on family and religious support systems as vital resources for gerontological social workers as they provide comprehensive services to older Korean immigrants.

Social workers serving Korean-Americans must deepen their understanding of Korean inter-generational dynamics in order to mobilize the family's strengths as it helps its older members to adjust to American culture. Considering the fact that most older Korean Americans were invited to live in the United States by their adult children and family members who have already settled there, social work practitioners must recognize the centrality of their "children" in older Korean Americans' lives. Social workers can provide both individual and family

counseling to improve inter-generational relationships and resolve problems that arise from conflicts between Korean adult children and their parents.

While social work practitioners may meet many older Korean-Americans who report close involvement with their children and grandchildren, they may also discover many older adults who are socially isolated from their ethnic communities and who also have little or no family support (Moon, 1996; Moon & Pearl, 1991). Social work practitioners must understand that the lack of such support increases elders' difficulties in adjusting to sickness and general functional decline. Social workers can serve a valuable role in attempting to help older adults maintain connections with culturally appropriate support systems. Referrals to Korean-American social service organizations and providing access to other culturally appropriate resources can help to alleviate older Korean-Americans isolation and dependency. When working with older Korean Americans, social workers must also appreciate the crucial role of the elderly immigrants. As older Korean Americans still occupy positions of authority and respect, older parents would establish positive impacts on children's successful adjustment by generally instilling values of achievement, generosity, loyalty, and self-discipline in their relationship with children.

Social workers also need to understand that living in an ethnic community has both positive and negative implications for older Korean immigrants. As they settle into familiar patterns with persons of similar backgrounds, this same familiarity may work to isolate the newly arrived Korean-American from available health care and other important social systems that are found only in the larger society. Older Korean-Americans frequently find themselves isolated by virtue of living with their adult children in suburban settings. Few elderly Korean immigrants share their personal problems with their adult children. In particular, older Korean

immigrants express concern about being a burden to their children and thus they strive to be as independent as possible. Others may expect emotional and financial support from their children and become depressed if it is not available. Korean-Americans' physical isolation and lack of expected emotional support are issues that social workers should continually assess.

As religiosity was found to be an essential asset for older Korean-Americans, social workers should know that Korean-American religious organizations can have an important role in facilitating Korean-Americans' adjustment to American life. Social workers should maintain collaborative relationships with such religious organizations. At the same time, in clinical settings, social workers should understand the role of religiosity as it affects individual well-being and should reaffirm the profession's commitment to respecting cultural diversity in this area. Understanding an older client's religiosity may help the social worker discover the older client's view of the world and understand subsequent client behavior. It is important to understand how older Korean adults define reality for themselves within a spiritual context. For example, suffering may be understood by older Korean Americans as a spiritual test by a greater power. If private prayer and devotion are sources of great comfort and serve as coping devices, social workers can respectfully encourage older clients to use them.

As immigration factors were found to be moderately associated with mental health outcomes for older Korean-Americans in this study, social workers should take into account the level of an elder Korean-American's acculturation when working with and the client. Acculturation is associated with learning English, being employed and developing a social support network. Particularly, this study demonstrated that language and transportation difficulties for these isolated older Korean immigrants remain critical challenges that social workers must be aware of and provide assistance with as needed. When social workers assist

immigrant populations, it is crucial to note that immigration itself is a stressful process for people adjusting to a new society and different cultural norms.

Similar to older Koreans, the current study found that many older Korean-Americans experience high levels of depression. Social work practitioners should be aware of the fact that older Korean-Americans generally pay little attention to and do not recognize mental health problems. Since many Koreans believe in harmony between mind and body, they do not distinguish between mental and physical health. When Korean older adults face a health problem, they first might seek help from their family. They then turn to spiritual healers, eastern medical professionals and only afterwards to western medical providers (Pang, 1999). Even after receiving a diagnosis of depression, many older Korean Americans refuse help from mental health providers and often hide this information from their families to avoid the stigma attached to such a diagnosis (Kim, Han, Kim, & Doung, 2002). They often think that the problem will resolve of its own accord as time elapses.

During the provision of mental health services, language poses another problem in social work practice with older Korean Americans. When Korean older immigrants are ready to seek help, they often face the problem of working with mental health providers who do not speak Korean and who are unable to provide adequate translation services. Although a translator is used when services are provided, many Korean older immigrants may feel uncomfortable during the treatment process because they cannot communicate directly and effectively with their provider. Social workers may face a considerable challenge in these situations, since the communication process is radically altered by the inability to converse efficiently and effectively. Language barriers may thus threaten social workers' attempts to establish rapport and to build trusting relationships with their Korean-American elderly clients.

Another issue is the stereotyping of Asian Americans as a “model minority.” A substantial body of scientific research over the past decade has documented that persons of Asian descent are as equally susceptible to mental health problems as are non-Asians (Wykle & Ford, 1999). Implicit in the assumption of positive Asian mental health is the popular notion that the close-knit family unit and ethnic community effectively deal with stressors that can lead to the development of psychopathology without the assistance of ‘outside’ mainstream intervention. However, this is not always the case among all older Asian-American immigrants. Such generalizations deflect attention from the real need of such persons for psychosocial intervention.

Research such as that produced by the current study highlights the need for culturally and ethnically appropriate intervention strategies to be used with Korean-Americans. For example, social workers could provide validation for older Korean-Americans as these persons place greater value on their quest for simplicity of life, quiet contemplation and spiritual growth. For younger Koreans planning to bring their parents to the United States, social workers could provide counseling regarding the best means of accomplishing a mutually satisfactory relocation to America. Instruction about the stress and the coping model could be helpful, as well as suggestions about handling frustrations during the adjustment process.

Older immigrants would also expect health care providers to be somewhat knowledgeable about and demonstrate a respect for their culture, customs, and social status. The manner in which Western mental health care providers show such respect may translate into increased use of such services by the Korean immigrant population. Social work and other organizations whose purpose is to serve the social, political, and health care needs of the Korean-American community would do well to establish and maintain good relations with local political and religious leaders. Cooperative efforts with these organizations could result in the preparation

of a cultural database about the local immigrant population. Community resources such as translation services, cultural healers, health care resources, and other useful information need to be identified. This shared database could be used as a basis for developing an ongoing immigrant cultural education program for health care providers. Programs could incorporate information about local language patterns, cultural courtesies, religion and beliefs about health and illness, food preferences, and the significance of various colors, numbers and other symbols.

Research

This section will discuss several issues relevant to empirical research with older minority populations. After considering the primary challenges in conducting gerontological research, some methodological problems that often occur in cross-cultural research with non-English speaking participants will be addressed. Research on the interaction between religion, age and health will also be discussed.

There are many challenges in conducting gerontological research with minority populations. In this study, the survey initially developed in English had to be translated into Korean and eventually validated by several experts. It was difficult to identify and recruit possible research participants. As older Koreans and Korean-Americans were not familiar with this type of research, they often were reluctant to participate in the project. The author had to individually assist some older Koreans who had vision problems and less education. However, most of the participants enjoyed their participation and freely exchanged their thoughts and feelings. Nevertheless, there are general barriers that hinder research with older populations. These include insufficient research funding, inadequate research training, and age discrimination. The recruitment and retention of older adults as research participants is also problematic. When taken together, these factors may inhibit gerontological research in general.

Methodological issues

When conducting mental health research with non-English speaking older participants, researchers should be aware of several methodological issues. Culturally sensitive measures should be used and data should be interpreted cautiously. Researchers and clinicians often assess depression among older adults from different ethnic and cultural backgrounds. Without consideration of different cultural norms and values among non- English-speaking populations, the same assessment methods are commonly used with all groups. Therefore, the validity and reliability of these assessments can be questioned when cultural variations are not taken into account. Many researchers and clinicians have raised concerns about the psychometric adequacy of assessment measures for older adults living in different cultures and speaking different languages (e.g., Jang, Small, & Haley, 2001).

Besides suggesting a valid and reliable Korean instrument for studying the Korean elderly, the present study provides a possible answer for researchers or practitioners who have concerns about using translated depression inventories because this study's instrument was proven to be reliable and valid. As it is difficult to differentiate aging-related psychological perceptions considered 'normal' from psychosomatic symptoms, researchers and practitioners often fear that instruments with a loading of physical symptoms may not accurately reflect depression among Korean elders. For example, in the GDS scale, older Koreans' responses to items such as "Do you feel your life is empty?" or "Do you think that most people are better off than you are?" were not definitive. Respondents often reported difficulty in answering these questions since they automatically assume that "Of course, my life is empty because I will never be younger. Isn't that simply because I'm getting older?" They also replied that it is not fair to compare them to other people. They often said, "Yes, I am better off than other people who are

living alone or who do not enjoy the full respect of their children. However, others might be better off than I am because they are healthier and wealthier than me.” In addition, based on the author’s personal experiences with Korean elders, it is strongly recommended that the GDS scale be changed to a 5-point Likert scale instead of a dichotomous “yes/no” structure. Many respondents commented on the difficulty of choosing only between “yes” and “no.” Since every culture has different linguistic idioms that express the concept of depression, the relationship between language and cognition should be explored. For example, in Korea, depression is often described as being in a place where “everything surrounding me is dark and black; my chest feels heavy as if a rock was sitting upon it, nothing gives me joy (‘jae-mi’), and I am not able to laugh with my whole heart” (Kim, 1995). Accordingly, it is recommended that some items relating to physical symptoms of depression be added to the scale.

Research on the mental health of Asian elders began less than twenty years ago (Kiefer et al., 1985). There is a lack of psychometrically sound measurement of the particular problems of this ethnic group and there are few demonstrably effective mental health treatments for this population. There are difficulties in determining the extent of mental health problems among ethnically diverse populations (Uba, 1994). The subjectivity inherent in the interview process may result in the misdiagnosis of such problems. Standardized psychological instruments have not been widely tested among older Asians (Sue, Nakamura, Chung, & Yee-Bradbury, 1994). Those instruments that are frequently used such as the Geriatric Depression Scale (GDS) and the Zung Self-Rating Depression Scale in many cases provide results that fall outside of “normal” ranges when used with Asian subjects (Jang et al., 2001; Fugita & Crittendon, 1990).

There have been few cross-cultural or cross-national studies of mental health in later life, perhaps for the reasons mentioned here. It is true that little attention has been paid to the

influence of cultures and ethnicity on depression (Gatz, 1995). There is a need for more research on late-life mental and physical health across cultures. Since the allocation of health care and financial resources will continue to be a critical issue for older adults, there will be greater demands on social work and other helping professions to intervene efficiently and effectively, based on empirical research about the specific problems of older adults.

In sum, the fact that most standardized measurement scales have been derived from samples of younger persons does not make them easily applicable to the accurate and valid measurement of older adults' status. The lack of appropriate and valid scales in languages other than English is an additional concern. Long-term follow up of elders is often difficult due to declines in physical and cognitive status, institutionalization and/or death. In those contexts, researchers should make long-term efforts to develop many standardized measurement scales appropriate for older populations and to expand those projects to minority populations with additional considerations of different cultures and linguistic subtleties

Research on the effect of social support on psychological well-being

This study also tested the significant effect of social support as an important coping resource in reducing the level of depression. Satisfaction with social support is known as one of the effective coping resources in three ways. First, positive interactions with others provide a sense of purpose, meaning, and guidance in life. In addition, emotional comfort influences a sense of well-being by bolstering feelings of self-esteem. As a result of satisfied interaction with important network members, older people come to believe that they are loved and valued. Finally, encouragement and support provided by significant others can reinforce feelings of personal control, which also plays an important role in maintaining healthy mental health.

Perceived social support has emerged as an important factor in determining specific coping strategies as well as levels of psychological well-being. As the path model showed, the composite score of social supports provided by family, friends, and significant others had a directly significant effect in reducing the level of depressive symptoms for both older Korean and Korean-American sample. These findings are in accord with outcomes of previous research on social support coping and health.

The data supported the conclusion that satisfaction with social support has a significantly direct effect on mental health outcome for both older Koreans and the Korean-American sample. Hence, the results of this study would help for a better understanding of the temporal causal relationship between the perceived adequacy of social support and mental health outcome. The measures of satisfaction with social support used in this study represent composite scores of the overall quality of the relations in the networks of older adults. To the extent that this is true, in further study, it is important to assess satisfaction with specific sources of support such as satisfaction with marital or parental relationships, relationship with friends or significant others. It would be also beneficial to explore the expectations or values regarding the exchange of support because, in particular, many older Korean parents still believe that it is the duty or obligation of the child to be a major source of support to the parent.

The measurement might be one of the issues about the links of social support and mental health outcome. Despite the intuitive appeal of this theoretical rationale, empirical studies examining the main effects of social support on psychological well-being have provided inconclusive findings: Some studies suggest that social support is an important predictor of mental health, whereas others fail to reveal a significant effect. Thus, researchers have devised a number of ways to assess social support because they have felt that at least part of the reason for

these contradictory findings is due to problems in the conceptualization and measurement of supportive social relations. As the literature has evolved, it has become increasingly clear that researchers must also examine the qualitative or evaluative aspects of social support. Many social support measures fail to capture the full complexity of the social support process because many studies did not assess the qualitative aspects of social support as much as the quantitative dimension. Considering the trend that the wide majority of studies involving adults have used the measure of the number of support network or frequency of contact with people, this study has the unique contribution to examine the perceived satisfaction with multiple support sources.

Although there appears to be adequate theoretical justification for the hypothesis that satisfaction with social support affects well-being, it could also be possible to offer an alternative explanation for the relation between these measures. It means that the causal relationship may be in the opposite direction: older adults who initially suffer from significant depressive symptoms may subsequently be less satisfied with their social support systems than are persons who enjoy better mental health. Moreover, older adults suffering from depression may actually receive less support because of the interpersonal problems created by their deteriorating physical and mental condition. Thus, in future study, it would be beneficial to test the opposite causal relationship model including the hypothesis that the more depressed people experience are more likely to be less satisfied with social support. Because the direction of causality between satisfaction with social support and depression is not clear, it is imperative that researchers need to assess the relationship between constructs with longitudinal data.

The results of the path analysis conducted in this study supported for the hypothesized model. As expected, stress-related factors such as poorer physical health and lower functional ability were more predictive of mental health outcome than socio-demographic characteristics.

The findings are consistent with the implications of the stress and coping model, in that physical stressor conditions are more predictive of mental health outcome. In Korean model, social support significantly mediated three stressors by buffering negative effects of stressors as a facilitating coping mechanism. In the context of the path model, perceived support should be understood as a personal resource that works to determine coping strategies as well as levels of psychological well-being.

Research on religiosity, health, and aging

This study examined the unique contribution of religiosity as an important coping resource for older adults. The relationships among religiosity, health and aging have important implications for social work researchers and practitioners. Interest in the religion-health connection has grown markedly in recent years. A decade ago, and even more recently, the suggestion that religion might influence mental or physical health outcomes was greeted with skepticism and even hostility by many researchers. It evoked images of faith healers and charlatans among the general public (Ellison & Levin, 1998). However, in academic circles, research interest in the relationship between religiosity and health among the elderly is growing in several fields, including sociology, psychology, health behavior and health education, psychiatry, gerontology, and social epidemiology (Ellison & Levin, 1998). How strong is the empirical evidence linking religious involvement and health outcomes? It appears that religion, in a broad sense, represents a protective factor that offers a small but significant primary preventive effect against morbidity in elderly populations. Considerable controversy has surrounded the relationship between religious involvement and mental health because most studies were conducted with small sample sizes, poorly validated or unreliable measures and cross-sectional methods. While some psychologists and psychiatrists (e.g., Jung) have waxed

positive about this association over the years, their theories were frequently overshadowed by more critical evaluations, especially those of contemporary skeptics (Ellison & Levin, 1998). Many of the great thinkers of our time have argued that religion is essential to the human experience, yet because of its value-laden content, it remains a controversial and difficult area of empirical inquiry (Sherrill & Larson, 1994). By linking religious coping with stress and mortality, the work that the author has presented here takes a modest first step toward reaching the elusive goal of illuminating the empirical relationship between religious and health in later life.

While the quality of basic social work research on religion and health is improving, more attention should be devoted to the theories that are devised and the measures used to evaluate them. Whereas many studies have demonstrated that there is a statistically significant relationship between various dimensions of religion and health, it is not easy to find a well-developed and intuitively coherent sense of why these relationships exist.

There might be at least four ways to deal with this problem. First, researchers need to gain deeper knowledge about classic theoretical works on religion such as Durkheim (1915) or Simmel's (1905) discussion of social relationships and religion (e.g., cited in Krause, 1997b). Second, better theoretical perspectives may be developed with our understanding of existing perspectives on aging. For example, Erikson's eighth stage of development in life and Butler's research on life review would be useful in understanding that one purpose of religion is to infuse life with a sense of meaning. Third, it is necessary to develop theories that have a uniquely gerontological focus because many investigators merely test propositions that have been formulated with younger adults in mind. Accordingly, we need to know more about how various dimensions of religious practice change over the life course and how a mature faith among older

population develops, why it is related to health, and why some elders develop a mature faith while others do not. Fourth, similar to data analysis used in this study, a causal modeling perspective may help to improve theoretical work on religion because typical studies tend to pit one domain against another in an effort to see which explains the most variance in health. A more useful strategy in future research would be to focus on the interrelationships among multiple dimensions of religiosity within a causal modeling framework. Estimating the direct, indirect, and total effects that operate through this sequence would provide a better sense of the process linking religion with health. Finally, it is critical to acknowledge that sound measurement goes hand-in-hand with well-articulated theory. As there have been many problems with the measurement of religiosity in later life, researchers should identify the key dimensions of religiosity and devise high-quality measures for each domain. As briefly mentioned, there is virtually no research on the measurement of religion among older Buddhists or older Muslims or older persons who practice traditional eastern religions. As the social work profession emphasizes more culturally diverse practice and research, rigorous qualitative work is needed urgently to fill this gap in the knowledge base.

Social policy for older Koreans

Korea has been undergoing great demographic changes and rapid socioeconomic development since the 1960s. There has been an increase in both the proportion and absolute number of elderly Koreans. The growth of the aging Korean population raises various issues such as establishing income security, health care, and social welfare systems for their use. Accordingly, some potential implications for Korean social work are suggested. These include understanding and respecting Korean elders and their assumptions regarding filial piety;

establishing income maintenance programs for Korean elders, and developing adequate health care systems for Korean elders. This section briefly examines these issues.

As the Korean government's basic policy for the older population largely depends on traditional family care arrangements, older people without adult children are often neglected. These vulnerable elders should be eligible for specialized social services including counseling, training for caregivers, adult day care, financial aid, home health care and health education. It is essential that the government increase its efforts in establishing basic economic security for all older Koreans. Most older Koreans take it for granted that they will receive financial help from their own children because personal resources such as property and savings as well as public resources such as pensions and public assistance are quite limited. In many cases, this financial support is not forthcoming due to their children's financial instability. Accordingly, there is a rising demand for social welfare programs to meet the needs of older Koreans.

The increase in the number of older Koreans also generates a substantial demand for long-term care and housing. To this point, as the traditional value of filial piety emphasizes the provision of personal care for one's parents by their children, the Korean family has traditionally provided for these needs of its older members. However, this persistent societal expectation strongly discourages families from accepting personal care services from non-family members and makes the family reluctant to seek professional assistance. Furthermore, formal institutional care and community-based programs are not well developed in part due to the lack of governmental involvement. Many Korean elders may have more difficulty obtaining necessary care at home due to other factors such as an overall reduction in family size and the changing roles of women who now work outside the home and thus are no longer able to provide care for their elderly relatives.

Health care costs for the elderly are much higher than for any other population (Choi & Suh, 1995). National medical insurance was inaugurated in Korea in 1989 with the purpose of extending health care benefits to the entire population. However, the cost of such insurance has been unaffordable for many Korean elders. The government must face this financial reality and provide comprehensive, affordable health care for Korean elders who live in poverty.

Mental health policy and services in Korea have not kept up with the demand for such services by older adults, nor have they demonstrated an understanding of the particular challenges and changing demographics of the elderly population (Choi & Suh, 1995). Although the need for mental health services for older adults and the efficacy of appropriate interventions have been well established, policies affecting access to services, service system coordination, the financing of care and the training of professional and nonprofessional service providers have frequently lagged far behind older adults' needs (Choi & Suh, 1995). Consequently, millions of older Koreans with significant mental health problems will not receive the professional care they require. This fact remains despite the reality of the continuing increase in the number of older Koreans. These dynamics have serious societal ramifications, since the economic and social costs of untreated mental health problems will only intensify the longer they remain unaddressed. Unfortunately, issues germane to mental health and aging policy have received little attention at the national level in Korea. However, the rapid growth in the population of older persons can potentially increase the overall incidence of mental illness and cognitive impairment.

Social policy for older immigrants

Immigration is a complex process and immigrants can find themselves in very different legal situations in the receiving nation depending on their social and material resources, as well as the receiving nation's immigration policy. In the United States, even individuals in the same

family can have different legal statuses. The ideal solution to such legal dilemma is naturalization, the process by which one becomes a citizen of the United States with full rights and privileges. Yet, citizenship is not immediately available to everyone who might desire it, nor is it easy to obtain. It is absolutely true for older immigrants with shorter length of residence in the United States.

This study also revealed that older Korean immigrants draw upon public assistance at far higher rate than younger immigrant groups, although the results were not included. In addition, regardless of their nation of origin, older immigrants use Supplemental Security Income (SSI), the income program for the impoverished elderly, at higher rates than native-born individuals (Binstock, 1999). This fact has important policy implications since the number of older individuals admitted to the United States as permanent residents has increased in recent years.

Given the economically vulnerable situation of many immigrants, and of elderly immigrants in particular, it is clear that economic need is a major force behind extended family living arrangement. SSI receipt is a reflection both of low personal economic resources and the ability to tap public sources. Without SSI an impoverished older person is entirely dependent on family members. Acquiring SSI, though, requires social and linguistic skills. Older immigrants who migrate later in life have less of an opportunity to become fluent in English or to learn to navigate the host society's institutions. Consequently, they remain more dependent upon their families than individuals who migrate earlier in life.

Therefore, the social welfare picture of immigrants is more complex and it is clear that compositional differences among groups influence their social resources, living arrangements, and their use of social welfare programs. In order to develop more informed social policies

related to immigration, it is imperative that we begin to better understand the consequences for social program use of the heterogeneity within the new immigrant population.

In addition, it is widely known that mental disorders and their treatment have a significant economic impact on American society, with an estimated annual cost of \$43.7 billion annually (Gatz, 1995). Depression is a common mental health problem in later life and has been associated with greatly increased medical morbidity in all age groups, especially the elderly (Blazer, 2002; Jang & Haley, 2002). Since many older adults simultaneously cope with physical illness, the effects of depression may be stronger than it might be in other population cohorts. This may be a significant factor in late life, when individuals typically experience an increase in physical illness. If one considers this fact in conjunction with the decline in quality of life, depression can have a major impact on the older population. Gender, ethnicity and financial status also influence access to health care (Jackson et al., 1995; Jenkins, 1988; Krause et al., 1998). There are several factors that also warrant attention when examining the economic impact of late life mental illness. Gender and ethnicity can both strongly influence access (financial and physical) to health care, treatment patterns, and other important elements related to outcome. Another important factor would be the possible underestimation of the cost of illness in later life.

Limitations

There are several limitations to this study. First, it is important to note that a convenience sample was used for the present research. The sampling frame for this research was obtained from social organizations in which Korean elders are active members. The sample may have been biased toward more mobile and healthier individuals who were willing to make a trip to the study sites to fill out the survey. Hence, the generalizability of the findings might be limited to community-based and active Korean elderly. Second, until recently, studies of religion and

mental health were often characterized by sampling and analytic limitations, such as small, unrepresentative samples, cross-sectional data and lack of appropriate statistical controls. This research also did not overcome those weaknesses in relation to religiosity and health studies. Researchers wishing to continue work in this area should address the limitations of this present study.

Additional specific limitations in this research follow. First, some of the key concepts that were involved to develop the main hypotheses were not measured explicitly. For example, the measure of acculturation did not include some crucial items such as language spoken and preferred, associations with Koreans and Americans, identifying oneself as Korean or American, food preferences, and attachment to Korean values and traditions. Second, the effects of random measurement error were not taken into account in the analyses. Although path analysis was used as an extension of the regression model in this study, the measurement model was not taken into account. Because most of measurements used in this study were not widely tested with Korean older populations, the reliability and validity might be not warranted. In order to reduce random measurement error, the full structural equation model combining measurement and path model together will be the best solution in future.

Third, in spite of the fact that there may be important group differences in the relationship between religiosity and depression in later life, this study did not consider the different value-laden characteristics of different religion. Finally, some measures such as acculturation level and physical health conditions were somewhat crude and not reliable. In particular, the applicability of the religious involvement scale to non-Christian populations should be further examined using confirmatory factor analysis.

On the basis of the findings that the Korean sample scored higher on depression, certain assumptions may be made. First, Korean society has experienced dramatic socio-cultural changes during the last four decades, with consequent effects on employment, family structures and mortality. During this period, many Korean elders have found it difficult to adjust to a rapidly changing system of social values. Second, a culturally different response style to questions relating to emotion may have caused higher GDS scores. Korean elderly are quite reluctant to respond positively to positive affect questions or to easily answer “yes or no” questions. When conducting similar cross-cultural research with non-English speaking populations, it will be important to use instruments that have culturally equivalent reliability and validity.

Future Research Directions and Recommendations

The goal of this study was to couple a well-developed theoretical rationale with sophisticated data analyses to examine the interface between coping mechanisms and depression in later life. Further work may challenge the findings presented in this study. Given the specific findings and the limitations of the data, what are the possible avenues for future research?

Korean Americans are a small but rapidly growing immigrant population in the United States for whom valid and reliable health information is needed. While a variety of behavioral health care utilization models have been used to explore the characteristics of users versus non-users of health care systems, they have not been fully effective in answering why older Korean immigrants are more depressed. Mental health care professionals need a more adequate understanding of the effects of culture and tradition on utilization of mental health care by Koreans and Korean-Americans. This improved understanding will hopefully lead to more culturally sensitive mental health practitioners and treatments.

Future research should address religious activity and mental health using a different, more religiously heterogeneous sample. The sample should be community-based and the study should be longitudinal in nature to improve upon our knowledge of these processes as they occur outside of institutional settings. Future measurement of religiosity should seek to determine not only what people do in regard to religion, but also how they perceive religion's purpose in their lives. A complementary approach to investigating religion-health linkages should specify various direct and indirect effects of religious involvement on health outcomes. Although satisfactory measures of both behavioral and functional aspects of religious involvement are not widely available, those relationships should be estimated via hierarchically organized regression models, path-analytic techniques, or perhaps best of all, structural equation models, with formal decomposition of the total and indirect effects of religious variables. This will permit researchers to test alternative and theoretically grounded models.

To advance research on religion, aging, and well-being, several steps are suggested. First, researchers in this area need to explore the potential mediating or moderating effects of various psychosocial constructs. In order to examine the unexplained 70% of variance from this study in future research, models investigating stressors' effects on well-being-related outcomes should include incorporated measures of known psychosocial and behavioral correlates of well being, such as self-esteem, mastery, stressful life events, and mental consequences resulted from tragic history the older Koreans and Korean Americans had experienced for a long time. Constructs such as self-esteem and social support represent resources that may be expected to buffer the impact of deleterious stressors; alternatively, they may reflect or be attributed in part to the influence of particular religious characteristics. Second, researchers should specify more precisely which dimensions of religious participation are beneficial to which outcomes. Religion

is a “multifaceted health-related phenomenon” (Levin & Vanderpool, 1991, p. 41) constituting an amalgam of public and private behaviors, affects, cognitions, experiences, and values that may not realistically be expected to relate similarly to disparate outcomes (e.g., depression, positive affect, life satisfaction, subjective health). Third, panel, longitudinal and representative studies are needed to establish the correct temporal sequence between religious involvement and health and well-being in structural models because determining conclusively which constructs antecede which outcomes cannot be accomplished through analyses of cross-sectional data.

The two important issues of filial piety and traditional living arrangements among Korean and Korean-American families should be further studied. It is important for researchers to know how the value of filial piety in Korea is changing among Korean adult children and how much Korean older adults still expect filial piety. The interplay between the indigenous culture of Korea and a preferred independent living arrangement influenced by western cultures is a critical research area. The author needs to continue to examine the changing culture and its impacts on elderly persons’ social status.

The lessons learned from this research are particularly important in understanding the stressors, coping processes and mental health needs of elders in Korea and elder Korean-Americans. Based on the review of the literature, on the present research findings, and on identification of trends, it is possible to make recommendations about needed services, sites, and modes of delivery.

1. Preventive mental health services must be offered in a variety of settings, including doctors’ offices, senior centers, neighborhood or community centers, and religious organizations or educational institutions. Since a limited number of older adults are served in community mental health centers and other traditional mental health settings,

services must be made available in locations where older adults and their families normally go.

2. Visits to mental health professionals must be encouraged in order to prevent mental health problems in the first place. Such an approach might go a long way toward reducing the stigma frequently associated with the use of mental health services.
3. Educational workshops that discuss transitions such as retirement, widowhood, and changes in health status must be provided. When such workshops are presented by social workers, they increase receptivity to the use of mental health services and community resources. Elders may eventually become more comfortable in attending such workshops and in telling others about these opportunities.
4. Families caring for older adults must be made aware of the availability of formal social services that will help them in their caregiving roles.
5. Linkages between aging and mental health care networks and providers must be strengthened.
6. Persons who provide services in senior citizen centers, congregate living facilities and nutrition sites must be more adequately trained in basic communication and helping skills.
7. There must be greater efforts in educating the general public about the mental health needs of the older population. Mass media must be utilized in these efforts.
8. Older adults must be given more opportunities to have major roles in developing their own programs. More support for self-help groups that address the problems and concerns of elders is needed.

9. Families should be encouraged to establish and maintain multi-generational events that recognize the uniqueness and importance of their elderly members.

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APPENDIX A
QUESTIONNAIRE IN ENGLISH



Dear Senior Members:

The present survey is being conducted with the approval of the University of Georgia at Athens. This research is being conducted by Eunkyung Yoon, doctoral student and Dr. Stacey Kolomer, School of Social Work at the University of Georgia, Athens, GA 30606. Investigators will be available to answer any additional questions if you have about this research at (706) 542-5445 via e-mail: eunyoona@arches.uga.edu and skolomer@arches.uga.edu

Enclosed is a brief questionnaire. This survey research's title is "Psychological well-being, social support, and religiosity among Korean older adults". The primary purposes of research are 1) to attempt to identify what contributes toward your psychological well-being, and 2) to propose collaborative community mental and social services for Korean older adults.

Please be advised that your participation is entirely voluntary. Thus, you can withdraw at any time without penalty. If you withdraw, all information about you will be returned to you or removed from the records. If any distress occurs, the researcher will be available to assist you.

Please be assured that your responses are completely anonymous and confidential because there is no way whatsoever for anyone, including the researcher, to identify who returned any given questionnaire. Also, there are no correct or incorrect responses in the survey. The findings of the survey will be shared with the University of Georgia and the Senior Programs and also will be reported only on a large group basis in public journals and center's newsletter.

Would you kindly take about 30- 45 minutes from your busy schedule to complete the enclosed questionnaire at your convenient time and return it with enclosed envelope to the researcher.

For questions or problems about your rights, please call or write:

Chris A. Joseph, Ph.D.,
Human Subjects Office, University of Georgia,
606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411;
Telephone: (706) 542-6514;
E-Mail: IRB@uga.edu.

1. Gender
☐ Male____ Female____
2. Age _____
3. Educational level
☐ Below 12th grade
☐ High School (12th grade)
☐ Some 2- year college
☐ 4-year college
☐ Graduate school
4. Marital status
☐ Married
☐ Never married
☐ Single (widowed, separated, divorced)
☐ Other
5. Monthly income
☐ < \$1000
☐ \$1001 – 2000
☐ \$2001 – 3000
☐ \$3001 – 4000
☐ \$4001 – 5000
☐ > 5001
6. Religious preference
☐ Protestant
☐ Catholic
☐ Buddhism
☐ Confucianism
☐ Other _____

7. Employment status
- ☐ Full-time (self-employed)
 - ☐ Part-time
 - ☐ Unemployed (retirement)
 - ☐ Others _____
8. Number of Household _____
9. Living arrangement
- ☐ Living alone
 - ☐ Living only with spouse
 - ☐ Living with children
 - ☐ Living with extended family
 - ☐ Others _____
10. Living place
- ☐ Private home
 - ☐ Apartment or condominium
 - ☐ Senior Living facility
 - ☐ Others _____
11. Year of Immigration _____
12. Your immigration motive
- ☐ Self independent – 1st generation
 - ☐ Following with children
 - ☐ Invitation from other families and relatives
 - ☐ Others _____
13. Are you a
- ☐ U.S. citizen
 - ☐ Permanent resident
 - ☐ Visiting
 - ☐ Others _____

14. In general, how would you rate your physical health ?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

14. In general, how would you rate your proficiency of English?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ None

Please indicate whether you have this problem

1. Arthritis	Yes	No
2. Ulcers	Yes	No
3. High Blood Pressure	Yes	No
4. Diabetes	Yes	No
5. Liver problem	Yes	No
6. Kidney problem	Yes	No
7. Heart disease	Yes	No
8. Nervous condition	Yes	No
9. Circulation problem	Yes	No
10. Depression	Yes	No
11. Back problems	Yes	No
12. Hearing loss	Yes	No
13. Vision loss	Yes	No
14. Other _____		

Choose the best answer for how you have felt over the past week

- | | |
|--|----------|
| 1. Are you basically satisfied with your life? | YES / NO |
| 2. Have you dropped many of your activities and interests? | YES / NO |
| 3. Do you feel that your life is empty? | YES / NO |
| 4. Do you often get bored? | YES / NO |
| 5. Are you in good spirits most of the time? | YES / NO |
| 6. Are you afraid that something bad is going to happen to you? | YES / NO |
| 7. Do you feel happy most of the time? | YES / NO |
| 8. Do you often feel helpless? | YES / NO |
| 9. Do you prefer to stay at home, rather than going out and doing new things | YES / NO |
| 10. Do you feel you have more problems with memory than most? | YES / NO |
| 11. Do you think it is wonderful to be alive now? | YES / NO |
| 12. Do you feel pretty worthless the way you are now? | YES / NO |
| 13. Do you feel full of energy? | YES / NO |
| 14. Do you feel that your situation is hopeless? | YES / NO |
| 15. Do you think that most people are better off than you are? | YES / NO |

Please circle your best answer about following statements:

1 = I can do without help
 2 = I can do with some help
 3 = I am completely unable to do

- | | | | |
|--|---|---|---|
| 1. Can you use the telephone | 1 | 2 | 3 |
| 2. Can you get to places beyond walking distance | 1 | 2 | 3 |
| 3. Can you go shopping for groceries | 1 | 2 | 3 |
| 4. Can you prepare your own meals | 1 | 2 | 3 |
| 5. Can you do your own housework | 1 | 2 | 3 |
| 6. Can you do your handyman work | 1 | 2 | 3 |
| 7. Can you do your own laundry | 1 | 2 | 3 |
| 8. Can you take medications in the right doses at the right time | 1 | 2 | 3 |
| 9. Can you manage your own money | 1 | 2 | 3 |

Please circle your answer about following statements

1 = strongly disagree
 2 = somewhat disagree
 3 = neutral
 4 = somewhat agree
 5 = Strongly agree

- | | |
|--|-------------------|
| 1. Married children should live close to parents | 1 2 3 4 5 |
| 2. Children should take care of their parents,
in whatever way necessary, when they are sick | 1 2 3 4 5 |
| 3. Children should give their parents financial help | 1 2 3 4 5 |
| 4. If children live nearby after they grow up,
they should visit their parents at least once a week | 1 2 3 4 5 |
| 5. Children who live at a distance should write to
their parents at least once a week | 1 2 3 4 5 |
| 6. The children should feel responsible for their parents | 1 2 3 4 5 |
-

Are you a beneficiary from the following welfare programs and services

- | | | |
|----------------------------------|-----|----|
| 1. Medicare (USA residents) | Yes | No |
| 2. Medicaid (USA residents) | Yes | No |
| 3. Social Security | Yes | No |
| 4. Food stamps (USA residents) | Yes | No |
| 5. Children's financial supports | Yes | No |
| 6. Personal Pension | Yes | No |
| 7. Others _____ | | |

-
1. How often do you usually attend religious services ?
 - ☐ Every week
 - ☐ About three times a month
 - ☐ About once a month
 - ☐ About every three months
 - ☐ Once or twice a year
 - ☐ Never
 2. Are you an official member of a church or other place of worship
 - ☐ Yes
 - ☐ No
 3. How many church clubs or organizations do you belong to or participate in (Number:)
 4. Besides regular service, how often do you take part in other activities at your office of worship
 - ☐ Every week
 - ☐ About three times a month
 - ☐ About once a month
 - ☐ About every three months
 - ☐ Once or twice a year
 - ☐ Never
 5. Do you hold any positions or offices in your church or place of worship
 - ☐ Yes No
 6. How often do you read religious books or other religious materials
 - ☐ Every day
 - ☐ 2-3 times a week
 - ☐ Once a week
 - ☐ 2-3 times a month
 - ☐ Once a month
 - ☐ Nearly never

7. How often do you watch or listen to religious programs on TV or radio
- ☐ Every day
 - ☐ 2-3 times a week
 - ☐ Once a week
 - ☐ 2-3 times a month
 - ☐ Once a month
 - ☐ Nearly never
8. How often do you pray
- ☐ Every day
 - ☐ 2-3 times a week
 - ☐ Once a week
 - ☐ 2-3 times a month
 - ☐ Once a month
 - ☐ Nearly never
9. How often do you ask someone to pray for you
- ☐ Every day
 - ☐ 2-3 times a week
 - ☐ Once a week
 - ☐ 2-3 times a month
 - ☐ Once a month
 - ☐ Nearly never
10. How religious would you say you are
- ☐ Very religious
 - ☐ Moderately religious
 - ☐ Slightly religious
 - ☐ Not at all religious
11. How important was religion in your home when you were growing up
- ☐ Extremely important
 - ☐ Fairly important
 - ☐ Not too important
 - ☐ Not important
12. How important is it for parents to send or take their children to religious services
- ☐ Extremely important
 - ☐ Fairly important
 - ☐ Not too important
 - ☐ Not important

Indicate how you feel about each statement by circling the appropriate number using the following scale:

1 = Strongly disagree
 2 = Mildly disagree
 3 = Neutral
 4 = Mildly agree
 5 = Strongly agree

- | | | | | | |
|---|---|---|---|---|---|
| 1. There is a special person who is around when I am in need | 1 | 2 | 3 | 4 | 5 |
| 2. There is a special person with whom I can share joys and sorrows | 1 | 2 | 3 | 4 | 5 |
| 3. My family really tries to help me | 1 | 2 | 3 | 4 | 5 |
| 4. I get the emotional help and support I need from my family | 1 | 2 | 3 | 4 | 5 |
| 5. I have a special person who is a real source of comfort to me | 1 | 2 | 3 | 4 | 5 |
| 6. My friends really try to help me | 1 | 2 | 3 | 4 | 5 |
| 7. I can count on my friends when things go wrong | 1 | 2 | 3 | 4 | 5 |
| 8. I can talk about my problems with my family | 1 | 2 | 3 | 4 | 5 |
| 9. I have friends with whom I can share my joys and sorrows | 1 | 2 | 3 | 4 | 5 |
| 10. There is a special person in my life who cares about my feelings. | 1 | 2 | 3 | 4 | 5 |
| 11. My family is willing to help me make decisions | 1 | 2 | 3 | 4 | 5 |
| 12. I can talk about my problems with my friends. | 1 | 2 | 3 | 4 | 5 |

If you had the following problems, do you think who would give you help the most

1. Family
2. Relatives
3. Friends & neighbors
4. Religious organization members
5. Professional agency

1. Translation	1	2	3	4	5
2. Housing	1	2	3	4	5
3. Family problem	1	2	3	4	5
4. Sickness	1	2	3	4	5
5. Financial problem	1	2	3	4	5
6. Loneliness	1	2	3	4	5
7. Sadness	1	2	3	4	5
8. Discouragement	1	2	3	4	5
9. Welfare	1	2	3	4	5
10. Exam for citizenship	1	2	3	4	5
11. Filling out forms	1	2	3	4	5
12. Shopping	1	2	3	4	5
13. Advisement	1	2	3	4	5
14. Legal consultation	1	2	3	4	5

What do you worry about the most? Please list only one _____

* Thanks for your participation. If you want to know the results from this survey, please contact the researchers individually. Please stay in health and peace.

APPENDIX B
QUESTIONNAIRE IN KOREAN

안녕하십니까 ?

본 설문조사는 미국 조지아대학 당국의 승인아래 실시되는 것입니다. 본 연구는 조지아대학 사회복지대학원에 소속된 윤은경 (박사과정)과 스테이시 골로머 박사에게 의해 실시되는 것입니다. 귀하가 설문지 작성시 의문이 있으시면 두 연구자들이 전화와 이메일을 통해서 기꺼이 응답해 드릴 것입니다. 미국연락처는 전화번호 (706) 542-5445, eunyoony@arches.uga.edu 혹은 skolomer@arches.uga.edu 이고 한국연락처는 전화번호 (82) 31-211-2587 eunyoony83@hotmail.com 입니다.

설문지를 동봉합니다. 본 설문지의 제목은 “ 한국노인들의 정신건강, 사회적 지원, 그리고 종교성과의 연관관계” 입니다. 본 연구의 목적은 첫째, 귀하의 정신건강에 영향을 끼치는 원인을 파악하고, 둘째, 한국노인들을 위한 지역사회와 연계한 사회사업방안을 제안하는데 있습니다.

설문조사 참여는 전적으로 자발적임으로 귀하는 언제든지 어떠한 불이익없이 설문조사를 철회할 수 있습니다. 철회시 귀하와 관련된 모든 정보는 귀하에게 반환되거나 기록에서 제외됩니다. 설문조사 도중 어떠한 불편이나 스트레스가 발생하면, 연구자가 귀하를 도와드릴 것입니다.

본 연구자를 포함한 어떤 사람도 누가 설문지에 응했는지를 판별할 수 없으므로, 귀하의 응답은 철저히 익명으로 비밀이 보장됨을 알려드립니다. 또한 이 설문에는 옳고 그른 대답이 없습니다. 설문조사 결과는 조지아대학과 귀하소속기관과 공유할 것이며, 또한 공공 저널에만 공개될 것입니다.

바쁘시더라도 잠깐 시간을 내셔서 30-45분간 이 설문을 작성하셔서 연구자에게 봉투에 밀봉하신 뒤 전해 주시면 대단히 감사하겠습니다.

감사합니다.

윤은경, 사회복지 석사

박사과정 학생

조지아대학 사회복지학과

귀하의 권리에 대해 의문이나 문제가 생겼을 경우, 조지아대학 인간관련 연구소에 크리스

조셉박사에게 연락바랍니다. 주소와 연락처는

Chris A. Joseph, Ph.D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411;
Telephone (706) 542-6514; E-Mail: IRB@uga.edu.

1. 성별 남 ____ 여 ____

2. 연령 _____

3. 교육정도

- ☐ 고등학교 졸업 이하
- ☐ 고등학교 졸업
- ☐ 전문대 졸업
- ☐ 4년제 대학졸업
- ☐ 대학원 이상

4. 결혼상태

- ☐ 기혼
- ☐ 미혼
- ☐ 독신 (사별, 별거 혹은 이혼)
- ☐ 기타

5. 월수입

- ☐ 월 100만원 이하
- ☐ 101 만원 – 200만원
- ☐ 201 만원 – 300 만원
- ☐ 301 만원 – 400 만원
- ☐ 401 만원 – 500만원
- ☐ 501 만원 이상

6. 종교

- ☐ 기독교 (개신교)
- ☐ 천주교
- ☐ 불교
- ☐ 유교
- ☐ 기타 _____

7. 취업상태

- ☐ 풀타임
- ☐ 파트타임
- ☐ 전업주부
- ☐ 실업
- ☐ 기타 (정년포함)

8. 가구수 _____

9. 주거형태

- ☐ 혼자 산다
- ☐ 배우자와만 함께 산다
- ☐ 자녀와 함께 산다
- ☐ 대가족과 함께 산다
- ☐ 기타 _____

10. 주거지

- ☐ 개인주택
- ☐ 아파트 혹은 콘도미니엄
- ☐ 노인전용 주거단지
- ☐ 기타 _____

11. 이민 년수 _____

12. 귀하는

- ☐ 미국시민권자
- ☐ 영주권자
- ☐ 방문비자
- ☐ 기타 _____

13. 일반적으로, 귀하의 신체적 건강상태를 진단한다면

- ☐ 완벽하게 건강한 편이다
- ☐ 매우 건강한 편이다
- ☐ 보통으로 건강한 편이다
- ☐ 건강치 못한 편이다

14. 일반적으로, 귀하의 영어구사능력을 평가한다면

- ☐ 완벽하게 구사하는 편이다
- ☐ 매우 잘 구사한다
- ☐ 보통으로 구사한다
- ☐ 잘 못 하는 편이다
- ☐ 전혀 못한다

다음과 같은 질병을 경험하고 계십니까

1.	관절염	예	아니오
2.	위궤양	예	아니오
3.	고혈압	예	아니오
4.	당뇨병	예	아니오
5.	간 (肝) 질환	예	아니오
6.	신장질환	예	아니오
7.	심장질환	예	아니오
8.	신경계 질환	예	아니오
9.	순환기 질환	예	아니오
10.	우울증	예	아니오
11.	척추 질환	예	아니오
12.	청력 장애	예	아니오
13.	시력 장애	예	아니오
14.	기타 _____		

 귀하가 지난 주에 느끼신 기분에 대해 응답해 주십시오

- | | | |
|--|---|-----|
| 1. 귀하의 삶에 기본적으로 만족하십니까 ? | 예 | 아니오 |
| 2. 귀하의 취미와 활동중의 많은 부분을 포기하셨는지요? | 예 | 아니오 |
| 3. 귀하는 인생이 허무하다고 느끼십니까? | 예 | 아니오 |
| 4. 귀하는 자주 실증이 나십니까? | 예 | 아니오 |
| 5. 귀하는 일상적인 것에 기분 좋게 느끼십니까? | 예 | 아니오 |
| 6. 귀하는 좋지 않은 일이 생길까봐 두려우십니까? | 예 | 아니오 |
| 7. 귀하는 대체로 행복하십니까? | 예 | 아니오 |
| 8. 귀하는 자주 무력함을 느끼십니까? | 예 | 아니오 |
| 9. 귀하는 외출을 하거나 새로운일을 하기보다는 집에 계시는
편이 낫습니까? | 예 | 아니오 |
| 10. 대부분의 사람들보다 귀하가 더 기억력에문제가 있다고 느끼십니까? | 예 | 아니오 |
| 11. 귀하는 현재 살고 계시다는 사실에 대하여 매우 흡족하십니까? | 예 | 아니오 |
| 12. 귀하는 현재의 자신이 매우 가치없는 존재라고 느끼십니까? | 예 | 아니오 |
| 13. 귀하는 자신이 원기 왕성하다고 생각하십니까? | 예 | 아니오 |
| 14. 귀하는 귀하의 처지가 희망적이 아니라고 보십니까? | 예 | 아니오 |
| 15. 귀하는 대부분의 사람들이 자신보다 더 나은 생활을 한다고
생각하십니까? | 예 | 아니오 |

 일상생활을 수행할수 있는 능력측정

1 = 도움없이 할수있다 2 = 다소의 도움이 필요하다

- | | | | |
|-----------------------------|---|---|---|
| 1. 전화를 걸수있다 | 1 | 2 | 3 |
| 2. 도보거리 이상의 먼 곳에 갈수 있다 | 1 | 2 | 3 |
| 3. 식료품 시장을 볼수 있다 | 1 | 2 | 3 |
| 4. 자신의 식사를 준비할수 있다 | 1 | 2 | 3 |
| 5. 자신의 집안일을 할수 있다 | 1 | 2 | 3 |
| 6. 자신의 집안밖일을 수리 혹은 관리 할수 있다 | 1 | 2 | 3 |
| 7. 자신의 세탁물을 세탁할수 있다 | 1 | 2 | 3 |
| 8. 정확한 시간에 정량의 약을 먹을 수있다 | 1 | 2 | 3 |
| 9. 자신의 금전적인 문제를 처리할 수있다 | 1 | 2 | 3 |

 귀하는 자녀의 효도에 관해 일반적으로 어떻게 생각하십니까

1. 절대적으로 반대한다
2. 다소 반대한다
3. 중립적이다
4. 다소 찬성한다
5. 절대적으로 찬성한다

1. 결혼한 자녀는 부모와 가까이 살아야 한다	1	2	3	4	5
2. 부모가 아프실때는 무슨 방법을 써서라도 부모님을 간호해야한다	1	2	3	4	5
3. 자녀는 부모님을 경제적으로 도와드려야 한다	1	2	3	4	5
4. 자녀가 성장후에 부모님 근처에 산다면, 적어도 일주일에 한번은 부모님을 방문해야한다	1	2	3	4	5
5. 먼 곳에 거주하는 자녀도 적어도 일주일에 한번은 편지나 전화를 통해서 안부를 전해야한다	1	2	3	4	5
6. 자녀는 그들의 부모님에 대해 책임감을 갖어야한다.	1	2	3	4	5

다음과 같은 공적인 혜택을 받고 계십니까?

1. 메디케어	예	아니오
2. 메디케이드	예	아니오
3. 사회복지연금	예	아니오
4. 푸드스탬프	예	아니오
5. 자녀로 부터의 금전적 도움	예	아니오
6. 연금	예	아니오

종교에 관한 질문

1. 얼마나 자주 종교행사에 참석하십니까?
 - ☐ 매주
 - ☐ 한달에 세번정도
 - ☐ 한달에 한번정도
 - ☐ 석달에 한번정도
 - ☐ 일년에 두번정도
 - ☐ 전혀 불참석

2. 귀하는 종교단체에 정식등록된 회원이십니까?
 - ☐ 예
 - ☐ 아니오

3. 얼마나 많은 종교단체에 속해 있거나 혹은 참석하고 계십니까 ?(____ 곳)

4. 정기적인집회이외에, 귀하는 얼마나 자주 종교와 관련된 다른 활동에 참석하십니까?
 - ☐ 매주
 - ☐ 한달에 세번정도
 - ☐ 한달에 한번정도
 - ☐ 석달에 한번정도
 - ☐ 일년에 두번정도
 - ☐ 전혀 불참석

5. 귀하는 현재 종교단체내에서 직함을 갖고 계십니까?
 - ☐ 예
 - ☐ 아니오

6. 귀하는 얼마나 자주 종교서적이거나 다른 종교적 인쇄물을 읽으십니까

- ☐ 매일
- ☐ 일주일에 2-3번
- ☐ 매주 한번정도
- ☐ 한달에 2-3번
- ☐ 매달에 한번정도
- ☐ 거의 안한다

7. 귀하는 얼마나 자주 종교적인 티비나 라디오 프로그램을 시청하십니까

- ☐ 매일
- ☐ 일주일에 2-3번
- ☐ 매주 한번정도
- ☐ 한달에 2-3번
- ☐ 매달에 한번정도
- ☐ 거의 안한다

8. 얼마나 자주 기도하십니까?

- ☐ 매일
- ☐ 일주일에 2-3번
- ☐ 매주 한번정도
- ☐ 한달에 2-3번
- ☐ 매달에 한번정도
- ☐ 거의 안한다

9. 얼마나 자주 다른 사람에게 귀하를 위해 기도해 달라고 하십니까?

- ☐ 매일
- ☐ 일주일에 2-3번
- ☐ 매주 한번정도
- ☐ 한달에 2-3번
- ☐ 매달에 한번정도
- ☐ 거의 안한다

10. 귀하는 얼마나 종교적이십니까?

- ☐ 매우 종교적이다
- ☐ 보통으로 종교적이다
- ☐ 다소 종교적이다
- ☐ 전혀 종교적이지 못하다

11. 귀하가 성장할때 귀하의 가정에 종교는 얼마나 중요했습니까?

- ☐ 절대적으로 중요했다
- ☐ 보통으로 중요했다
- ☐ 그렇게 중요하지 않았다
- ☐ 전혀 중요치 않았다

12. 부모가 자녀를 종교행사에 보내거나 데려가는 것이 얼마나 중요한가?

- ☐ 절대적으로 중요하다
- ☐ 보통으로 중요하다
- ☐ 그렇게 중요치 않다
- ☐ 전혀 중요치 않다

인지된 지지요소의 다면적 척도

1 = 절대적으로 반대한다
 2 = 다소 반대한다
 3 = 중립적이다
 4 = 다소 찬성한다
 5 = 절대적으로 찬성한다

- | | | | | | |
|--------------------------------------|---|---|---|---|---|
| 1. 귀하가 도움이 필요할때 특별히 도와 줄 사람이 있다 | 1 | 2 | 3 | 4 | 5 |
| 2. 귀하와 기쁨과 슬픔을 같이 나눌 특별한 사람이 있다 | 1 | 2 | 3 | 4 | 5 |
| 3. 귀하의 가족들은 귀하를 진정으로 도우려고 한다 | 1 | 2 | 3 | 4 | 5 |
| 4. 귀하의 가족들로부터 필요한 정신적 지지와 도움을 받는다 | 1 | 2 | 3 | 4 | 5 |
| 5. 귀하에게 진정한 안식이 될만한 특별한 사람이 있다 | 1 | 2 | 3 | 4 | 5 |
| 6. 귀하의 친구들은 귀하를 진정으로 도우려고 한다 | 1 | 2 | 3 | 4 | 5 |
| 7. 문제가 생겼을때 귀하는 친구들에게 의지한다 | 1 | 2 | 3 | 4 | 5 |
| 8. 문제가 생겼을때 귀하는 가족들과 상의 한다 | 1 | 2 | 3 | 4 | 5 |
| 9. 귀하와 기쁨과 슬픔을 같이 나눌 친구들이 있다 | 1 | 2 | 3 | 4 | 5 |
| 10. 귀하의 기분을 생각해 주는 특별한 사람이 있다 | 1 | 2 | 3 | 4 | 5 |
| 11. 귀하의 가족은 귀하가 결정을 내리는 데 기꺼이 도움을 준다 | 1 | 2 | 3 | 4 | 5 |
| 12. 귀하는 친구들과 귀하의 문제를 논의할 수 있다 | 1 | 2 | 3 | 4 | 5 |

다음과 같은 문제가 생겼을때, 누가 귀하에게 가장 큰 도움을 줄수 있을 거라 생각하십니까?

1 = 가족
 2 = 친척
 3 = 친구나 이웃
 4 = 종교단체의 회원
 5 = 전문적인 기관

1. 교통편이 필요할때	1	2	3	4	5
2. 주거문제	1	2	3	4	5
3. 가족문제	1	2	3	4	5
4. 몸이 아플때	1	2	3	4	5
5. 경제적인 문제	1	2	3	4	5
6. 외로울때	1	2	3	4	5
7. 좌절했을때	1	2	3	4	5
8. 복지문제	1	2	3	4	5
9. 시민권 신청	1	2	3	4	5
10. 서명이 필요한 서류 작성시	1	2	3	4	5
11. 쇼핑	1	2	3	4	5
12. 일반적 조언이 필요할때	1	2	3	4	5
13. 법적인 조언이 필요할때	1	2	3	4	5

현재 가장 걱정되는 문제는 무엇입니까? _____