The Relationship between Social Support and Health-Related Quality of Life among Korean American Nursing Home Residents

by

Su-Jeong Park

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Professor Bernadette R. Hadden

Date — Chair of Examining Committee

Professor Harriet Goodman

Date — Executive Officer

Professor Anthony Sainz

Professor Roberta Graziano
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

ABSTRACT

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Advisor: Professor Bernadette R. Hadden

This descriptive and exploratory mixed-method study examined the relationship between social support and health-related quality of life among Korean American nursing home residents. It examined the social support networks of the Korean American nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators. A cross-sectional survey involving face-to-face interviews (using the social support questionnaire) and data extraction from an existing dataset (Minimum Data Set-MDS) on a sample of 73 cognitively intact Korean American nursing home residents were utilized to examine and understand the relationship between social support and health-related quality of life indicators.

Bivariate and multiple regression analyses revealed that social support had main and interactive effects on health-related quality of life indicators. In the bivariate analysis, the appraisal support variable was significantly associated with ADL impairments, depressive symptoms, and self-rated health. In addition, satisfaction with support person was significantly associated with depressive symptoms and self-rated health. Other social support variables, including negative behaviors (being hurt or being upset), perceptions

of giving, and perceptions of support were significantly associated with self-rated health among Korean American nursing home residents.

After controlling for the covariates, four social support variables were found to be predictive of depressive symptoms: negative behaviors; perceptions of control; frequency interacting with negative behaviors; and negative behaviors interacting with perceptions of control. In addition, perceptions of control and negative behaviors were found to be predictive of negative self-rated health among Korean American nursing home residents.

These findings demonstrate the most important sources and types of social support for Korean American nursing home residents and suggest interventions that may help facilitate their quality of life in a nursing home setting. Implications for social work practice and future directions for research are also discussed.

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DEDICATION

This dissertation is dedicated to my parents, Singil Park and Oksoon Kim.

Without their devotion, love, sacrifice, and unwavering faith in me,

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CHAPTER I. INTRODUCTION

Background of the Study

Demographics and Long-Term Care Needs among Frail Elders

Americans have witnessed a dramatic change in the demographics of the older population. The number of people aged 65 and over increased from 4.1% of the total population in 1900 to over 13% of the total population (U.S. Census Bureau, 2010). Between 2000 and 2010, the population aged 65 and over increased at a faster rate (15.1%) than the total U.S population (9.7%) (U.S. Census Bureau, 2010). The number of people aged 65 and over is projected to increase from about 34 million in the late 1990s to 88.5 million by 2050, and will comprise approximately 20% of the total U.S. population (Administration on Aging, 2005a; U.S. Census Bureau, 2010).

The population aged 85 and older, referred to as the "oldest-old," is the fastest growing proportion of the elderly population (Berkman & D'Ambruoso, 2006; Hooyman & Kiyak, 2008). With a 500 percent increase from 1960 to 2005 among the "oldest-old," those aged 85 and over comprised more than 13% of the aging population (Administration on Aging, 2005a). In the 2010 Census, the population aged 85 to 94 made up 12.6% of the population aged 65 and over (U.S. Census Bureau, 2010). The population aged 95 and over also represented 1.1% of the older population (U.S. Census Bureau, 2010). The "oldest-old" has been expected to increase fivefold between 1996 and 2050 (Kolb, 2003).

Life expectancy at birth in the United States has gone from 47 years in 1900 to 77.9 years in 2005 and is expected to reach 82.6 years in 2050. Approximately four out of five individuals can now expect to reach age 65, at which point there is a better than 50% chance of living past age 80 (National Center for Health Statistics, 2006). In addition, a five - to six- year gender difference in life expectancy is projected, with females and males born in 2005 expected to reach 80.4 and 74.1 respectively (National Center for Health Statistics, 2006).

This significant increase in the elderly population poses challenges for the social welfare state. The increase in the elderly population produces much greater demands on social welfare institutions, including Medicare, Medicaid, Social Security, senior housing programs, and other entitlement programs. A consequence of this trend is an increased demand for social, health, and long-term care services (Berkman & D'Ambruoso, 2006). These demographic changes in the elderly population will undoubtedly increase the long term care needs among frail and chronically ill elders (Moody, 2006). With increasing longevity, a large number of individuals will also eventually need assistance from informal or formal service providers, or both (Kolb, 2003).

As the older population grows, the prevalence rate of diseases and chronic conditions among the elders increases. It was indicated that more than 80% of community-dwelling elders have at least one chronic condition but this does not necessarily interfere with their activities of daily living or ADLs (e.g., cooking, dressing, bathing, toileting) (Centers for Disease Control and Prevention, 2003). Approximately 20% of elders suffered from a mild degree of functional impairment that alters the daily

routines of all elders currently in need of long-term care (Federal Interagency Forum, 2006; Merck Institute, 2002). Studies reported that functional impairment is a common occurrence among older adults and the proportion of older adults experiencing functional impairment is expected to increase with the growth of the older population (Crimmins, 2004; Putnam & Stark, 2006). One of the factors contributing to the long-term care needs of elders is chronic physical impairment resulting from such conditions as osteoarthritis, osteoporosis, Parkinson's disease, and cardiovascular disease. The physical deterioration of elders and the extent of disability can contribute to their physical and behavioral dependency (Horgas, Wahl, & Baltes, 1996; Putnam & Stark, 2006).

Another factor contributing to the long-term care needs among elders is mental disorders, such as dementia and depression. Dementia, as an organic mental disorder involving progressive deterioration of the capacity to think and learn, affects between 5 to 45% of the older population (Gatz & Smyer, 2001). Senile dementia of the Alzheimer's type (Alzheimer's disease) is the most common dementia in later life. It is estimated that 10% of all persons aged 65 and over, and 29% of those age 85 and over, have clinical symptoms of Alzheimer's disease (Hebert, Scherr, Bienias, Bennett, & Evans, 2003). Dementia manifests itself as a gradual decline in cognitive functions, including memory, learning, comprehension, attention span, judgment, language, speech, and abilities required to engage in activities of daily living. It also causes both behavioral and personality changes that are likely to contribute to the loss of self-care capability, which eventually requires full-time assistance (Hooyman & Kiyak, 2008; Kane, Kane, & Ladd, 1998; Toseland & Parker, 2006).

Depression is the most common mental disorder in later life (Blazer, Hybels, & Pieper, 2001; Hooyman & Kiyak, 2008). Estimates of the incidence of depression range from 10% to 30% in community-dwelling older adults (Blazer et al., 2001; Gallo & Lebowitz, 1999; Hybels, Blazer, & Pieper, 2001). Thus, the prevalence of depression increases as one moves from community settings (1% to 3%) to institutional settings, such as nursing homes (12% to 30%) (Payne, Sheppard, Steinberg, Warren, Baker, & Steele, 2002; Rovner, German, Brant, Clark, Burton, & Folstein, 1991; Unutzer, Katon, Sullivan, & Miranda, 1999). Even though the prevalence of depression in old age varies, it is clearly indicated that depressive symptoms and disorders are related to social withdrawal, social isolation, physical complaints, and functional deterioration (Horgas et al., 1996; Moody, 2006). In other words, depression affects physical, mental, and psychosocial functioning (Gellis, 2006).

The extent of disabilities and need for assistance in personal care activities increase progressively with age. Approximately 10.5% of elders aged 65 through 79 need some assistance and 51% of those 85 years or older require personal care (Administration on Aging, 2005b). It is expected that 30% of elders over age 65 will have activity limitations that require some assistance by 2030 and 20% of this population will have severe limitations in activities of daily living (Administration on Aging, 2005b).

The growth of the older population, combined with the increase in major chronic conditions and mental disorders, has placed greater demands on the health care system, such as long-term care services. Long-term care (LTC) essentially involves a diverse set of health care, personal care, and social services for people who need assistance with

daily living. The need for such assistance is the result of chronic physical, functional, or mental disabilities and the subsequent loss of the ability to function independently on a daily basis (Kane et al., 1998; Moody, 2006; Mui, Choi, & Monk, 1998). The settings for long-term care are generally divided into two types: institution-based (primarily nursing homes) and community-based (home care, visiting nurse services, nutrition programs, and other formal and informal services) (Moody, 2006; Mui et al., 1998).

The modern history of long-term care is largely dominated by the nursing home (Kane et al., 1998). The term "nursing home" refers to any residential setting providing some degree of nursing and personal care to elders with chronic disease, functional disabilities, or significant cognitive impairments (Johnson & Grant, 1986; Jones, 2002; Kane et al., 1998). There are about 17,000 Medicare and Medicaid certified nursing homes in the United States, with more than 1.6 million beds (Administration on Aging, 2005b). Approximately 40 percent of all people aged 65 and over in the United States spend some time in a nursing home, although only about 5 percent are in a facility at any specific time (Kolb, 2003; Moody, 2006). In the 2010 Census, approximately 1.3 million people aged 65 and over were in skilled-nursing facilities in 2010, representing 3.1% of the total population aged 65 and over (U.S. Census Bureau, 2010).

The growth in the nursing home population is partially attributed to medical technology and increasing longevity (Moody, 2006). Some of the factors that increase the chances of nursing home placement are cognitive impairment, chronic disability, advanced age, and hospital stay (Moody, 2006). Several studies reported that elders with severe cognitive impairments and ADL impairments are more likely to move to nursing

homes, whether or not they have a family caregiver (Gwyther & Kane, 2006; Friedman, Steinwachs, Temkin-Greener, & Mukamel, 2006; Vourlekis & Simons, 2006).

Labor-force participation of women is another important contributing factor to the need of nursing home placement of the elderly, as women's employment can diminish availability for providing care for elders in the community. Extensive studies demonstrated that females are the primary caregivers within their families (Bumagin & Hirn, 2001; Cancian & Oliker, 2000; Hagestad, 2000; Kolb, 2003). It is clearly indicated that structural change, such as the lack of availability of family members to assist as caregivers due to women's increased participation in the labor force, makes it difficult for families to provide necessary care in the community (Kolb, 2003). Therefore, more people are admitted to nursing homes to receive sufficient care.

In terms of resident characteristics, the typical nursing home resident is female (72 %), White (84.8%), with a diagnosis of dementia (40%), and over the age of 75 (75%), although 40% of all nursing home residents fall into the demographic category of "oldest old." (Centers for Medicare and Medicaid Services, 2001; Seperson, 2002). In terms of degree of assistance, more than a third of all residents receive extensive assistance with four of five activities of living (CMS, 2001), such as eating (47%), dressing (86.5%), bathing (93.8%), toileting (56%), and transfers (29%) (Jones, 2002).

Due to increasing long-term care options and a preference for remaining in one's own community, the population 65 and older living in nursing homes has been declining in recent years, from 5.4 percent in 1985 to 4.5 percent (CMS, 2001; U.S. Census Bureau, 2000). However, data clearly demonstrate that nursing home care is a resource that many older adults ultimately use (Hooyman & Kiyak, 2008; Moody, 2006). Moody (2006)

estimated that up to 40% of those who reach age 65 will live in a nursing home at some point before they die. Several studies reported that there will be a significant demand for nursing home care, particularly as the first baby boomers reach the age of 85 (Knickman & Snell, 2002; U.S. Senate, Special Committee on Aging, 2002). It is also projected that more than 4 million people will live in nursing homes by 2040 (Moody, 2006; Walker, 2002). Another study (Lakdawalla, Goldman, Bhattacharya, Hurd, Joyce, & Panis, 2003) also showed that future cohorts of older adults are predicted to have greater disability due to the rise in chronic health conditions such as asthma and obesity, which could create an increased need for nursing home care.

Quality of Life Issues

Quality of life becomes an important social welfare issue as greater numbers of individuals live longer lives. Increasing longevity brings an increased demand for services to address the complex health and welfare needs of the elderly. Quality of life is an important aspect of the evaluation of health and social services, especially among the frail elderly who suffer from multiple chronic conditions (Arnold, 1991). At the present time, the main goal of health and social services to the elderly is to enhance the well-being and quality of life of the elderly.

Quality of life is a multidimensional concept encompassing social, psychological, and physical domains (Birren, Lubben, Rowe, & Deutchman, 1991; Brod, Stewart, Sands, & Walton, 1999; Herr & Weber, 1999; Lawton, 1991). The term refers to people's overall evaluation of their lives in general or of various components of life such as social life, financial situation, or living situation (Arnold, 1991; Brod et al., 1999). Arnold (1991) defined quality of life as complex, involving both objective and subjective

components. Objective components include health status, financial resources, functioning, and social contact. In contrast, subjective components include happiness, life satisfaction, and self-esteem (Arnold, 1991). In a similar vein, Lawton (1991) defined quality of life as "the multidimensional evaluation, by both intrapersonal and social-normative criteria, of the person-environment system of the individual" (p. 6).

Quality care in a nursing home setting is understood to involve not only medical and personal care and functional assistance but also quality of life for the residents (Vourlekis & Simons, 2006). Quality of life in a nursing home became an important focus after the Institute of Medicine issued an influential report in 1986 recommending that quality of life be a regulatory condition for nursing home certification (Institute of Medicine, 1986). The report defined quality of life in a nursing home as "a basic sense of satisfaction with oneself, the environment, the care received, the accomplishment of desired goals, and control over one's life" (p. 51).

Quality of life within the nursing home setting is a complex concept. A variety of theoretical models describe the components of quality of life in long-term care settings. Bennett (1980) identified quality of life in terms of satisfaction of basic human needs, including physiological, safety and security, social, self-esteem, and accomplishment. Lawton (1991, 1994) delineated four general sectors of quality of life: psychological well-being, behavioral competence, objective environment, and perceived quality of life. Kane and colleagues (Kane, 2003; Kane, Kling, Bershadsky, Kane, Giles, & Degenholtz, 2003) proposed eleven domains for quality of life: autonomy, functional competence, privacy, dignity, meaningful activity, individuality, enjoyment, security, relationships, spiritual well-being, and comfort.

A survey of residents, families, and staff yielded a multidimensional definition of quality of life, including the socio-emotional environment, the physical environment, care issues, abilities, autonomy, and morale (Cohn & Sugar, 1991). This study found that residents, families, and staff identified quality of life in terms of domains that validated their own roles. Residents' perceptions of quality of life identified morale and attitudes; staff focused on care issues; and families emphasized activities and access to medical care. The same study found similarities among residents, families, and staff in that all groups recognized the significance of the social-emotional environment (social networks). Similarly, another study about the meaning of quality of life identified three components: the importance of social interactions, caring for oneself, and helping others (Aller & Coeling, 1995).

Quality of life for the nursing home resident may be better understood by a study of the interrelationships of its components. The relationship between social interactions and health outcomes is a determinant of quality of life. Epidemiological studies of older adult populations have demonstrated that social relationships are a predictor of mortality. Study findings indicated that inadequate social support networks are associated with an increase in mortality (Berkman, 1984; Bosworth & Schaie, 1997; Ell, 1984; Lubben & Gironda, 2003; Lyyra & Heikkinen, 2006; Uchino, 2004). One study reported that older adults with limited social ties or support are 3.6 times more likely to die within five years than those with extensive social contacts and support (Blazer, 2006). Similarly, several studies demonstrated that social isolation contributes to a higher risk of disability and early death, although it is not clear if social support is related with reduced mortality risk

(Findlay, 2003; Lyyra & Heikkinen, 2006; Moren-Cross & Lin, 2006). One study reported that participation in social activities and frequent social networks with friends and relatives reduces the likelihood of mortality by one-half for elderly subjects (Steinbach, 1992).

Social networks not only promote the physical well-being of elderly residents by encouraging healthy behaviors and rendering tangible aid but also enhance the more subjective aspects of quality of life of elderly residents (Thoits, 1995). These networks give meaning to the lives of the residents, help maintain links with past roles and life status, and provide confirmation or reassurance of personal worth. Social support contributes to elders' well-being through personal interactions that mitigate the negative effects of stressors of daily life (Antonucci, 1990). In other words, social support provides a direct and beneficial effect for the resident by meeting their common human needs for affection, a sense of belonging, companionship, financial assistance, physical assistance, and informational assistance. It acts as a buffer against the deleterious effects of institutionalization.

Statement of the Problem

It is indicated that there has been substantial growth in the segment of the U.S. population that is ethnically diverse and older in age. Among persons aged 65 and over, ethnic minorities comprised 20.1% in 2010 and will comprise 23.6% in 2020 (Administration on Aging, 2010). By the year 2050, non-Whites will comprise approximately 50% and those aged 65 and older will make up about 40% of the total

older population (Administration on Aging, 2009; Angel & Angel, 2006). In essence, the minority population aged 65 and over is projected to increase 172% between 2008 and 2030, compared with a projected 64% increase for older Whites (Administration on Aging, 2009). The minority aged population is expected to more than double in proportion during the next half century (Moody, 2006).

Among ethnic minorities, the elderly Asian American population has grown faster than any other ethnic group in the United States. Compared with a 12% increase in the total elderly population between 1990 and 2000, the population of elders among Asian Americans increased 78% (Min & Moon, 2006). In addition, Asian Americans have comprised the largest percentage (43.5%) of the older immigrant population. Among these minorities, Koreans are one of the most rapidly growing immigrant groups in the United States (U.S. Census Bureau, 2009). There are currently over 1.1 million Koreans of all ages in the U.S., placing them fourth in number of Asian Americans after Chinese, Filipinos, and Japanese (Chee, 2004; Y. M. Lee, 2007; Mui, 2001; U.S. Census Bureau, 2009). In 1990 and 2008, 4.2% and 7.6%, respectively, of the total Korean American population were aged 65 and over, compared with 14.5% of the general U.S. population (U.S. Census Bureau, 2009). The number of Korean American elders is projected to increase over time due to their continued immigration to the United States (U.S. Census Bureau, 2009).

In terms of the prevalence rate of chronic conditions and the extent of disabilities among ethnic minorities, ethnic minorities experience higher rates of functional impairment than whites (Hooyman & Kiyak, 2008). A few studies demonstrated that African Americans and Latinos are twice as likely as whites to report chronic problems

with activities of daily living and have higher rates of disability (Federal Interagency Forum, 2006; Ferraro & Kelly-Moore, 2005; Kelly-Moore & Ferraro, 2004). Asian Americans are generally defined as a healthy minority, especially in terms of perceived health status, health-promoting behaviors, and exposure to health risk behaviors (Min & Moon, 2006). However, several studies showed that Asian Americans have higher rates of chronic conditions than their white counterparts, such as hypertension, arthritis, cardiovascular disease, and osteoporosis (Kim, Juon, Hill, Post, & Kim, 2001; Min & Moon, 2006; Villa, Wallace, Moon, & Lubben, 1997). In addition, more Asian American elders than whites suffered from mood disorders (Min, Moon, & Lubben, 2005; Mui, 2001, 2003; Shibusawa & Mui, 2001). Studies demonstrated that the prevalence rate of depression is higher than the general elderly population, with the highest rate among Korean Americans (Min, et al., 2005; Mui, 2001).

The rapid increase of ethnic minorities greatly affects services for the aging. Representation of these ethnically diverse and rapidly growing segments of the population in the health care system, including nursing home care, is increasing in the U.S. In terms of nursing home use, ethnic minorities currently comprise only a small portion of the nursing home population. It is indicated that the numbers of ethnically diverse nursing home residents are likely to increase in accordance with the changing racial profile of the U.S. population (U.S. Census Bureau, 2004a). In addition, members of ethnically diverse families who have not used nursing homes in the past are now interested in doing so (Kolb, 2003). Data showed that 10.4% of the elderly who are African American and 3% who are Latino, Asian American, or Pacific Islander live in nursing homes (NCHS, 2000). Another study indicated that there has been a sharp

increase in nursing home use among African Americans (Redfoot & Pandya, 2002).

Kolb (2007) stressed that cultural attributes, including language, traditions, values, and norms, are influential in shaping the experiences of nursing home residents. She also demonstrates the uniqueness and the effects of cultural traditions and history related to ethnicity and race on nursing home residents (Kolb, 2003, 2007). However, due to lack of awareness and understanding of the culturally unique aspects of residents' attitudes, preferences, and behaviors, disparities in the quality of nursing home care by race have been identified, creating a "two-tiered system" (Mor, Zinn, Angelelli, Teno & Miller, 2004).

Several studies report that quality of life and social support may be differently interpreted, or biased, for a subgroup due to cultural differences in attitudes, norms, and behaviors (Cella, Lloyd, & Wright, 1996; Geisinger, 1994; Napoles-Springer & Stewart, 2001; Warnecke, Johnson, Chavez, Sudman, O'Rouke, Lacey, & Horm, 1997). Cultural factors may also influence response styles or response sets to social support and quality of life questions (Byrne & Campbell, 1999; McHorney, 1996; Warnecke et al., 1997).

Despite the well-documented extent of quality of life and social support studies for majority populations in a nursing home setting, there have been few or no empirical studies of social support and the quality of life for an ethnically diverse range of nursing home residents, particularly among Korean American nursing home residents. With the increased life expectancy and an increase in the population of Korean American elders, the need for long-term care services for them and their utilization of nursing homes have increased greatly. However, there is insufficient information about Korean-American

nursing home residents. In other words, little is known about social support and health-related quality of life issues in relation to Korean American nursing home residents.

Significance of the Study

With the emergence and acknowledgement of the increasing number of elderly Korean immigrants in the United States, much of the research on elderly Korean American immigrants has mainly focused on physical and mental health issues in the community (Ahn, 2005; Chee, 2004; Cheung, Leung, & Cheung, 2011; Chun, Enomoto, & Sue, 1996; Han, Kim, Lee, Pistulka, & Kim, 2007; Hurh & Kim, 1990a; Jang, & Chiriboga, 2010, 2011; Jang, Kim, & Chiriboga, 2005a, 2005b, 2006a, 2006b, 2010, 2011; Jang, Kim, Hansen, & Chiriboga, 2007; Kim, 2002; Kim, Han, Shin, Kim, & Lee, 2005; Kim, Kim, Juon, & Hill, 2000; Kim, Moon, & Shin, 1997; Kim et al., 2001; Koh, 1998; Y. M. Lee, 2007; Lee, Crittenden, & Yu, 1996; Lee, Diwan, & Yeo, 2010; Lee, Lee, & Diwan, 2010; Lee, Lei, & Sue, 2001; Lee, Moon, & Knight, 2004; Lee, Yeo, & Gallagher-Thompson, 1993; Min et al., 2005; Mui, 2001; Mui & Kang, 2006; Mui, Kang, Kang, & Domanski, 2007; Pang, 1995, 1998; Shin, Shin, & Blanchette, 2002; Villa et al., 1997; Wong, Yoo, & Stewart, 2005, 2007; Yamamoto, Rhee, & Chang, 1994).

However, there are only a few studies that describe the unique need for long-term care services for elderly Korean American immigrants in the United States and their utilization of nursing homes (Jang, Kim, Chiriboga, & Cho, 2008; Min, 2005). Although one recent study explored the characteristics, needs, and experiences of Korean American nursing home residents (Park & Kang, 2007), few empirical studies have been performed

exploring the life of Korean American nursing home residents and their issues and unique needs in a nursing home setting. Furthermore, a literature search indicates that the present study will be the first of its kind to examine the relationship between social support and health-related quality of life issues of Korean American nursing home residents. No published literature has dealt with the specific issues experienced by Korean American nursing home residents.

This study will examine the social support networks of Korean American nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators. This study will identify those features of the support networks that have the greatest potential for facilitating Korean American residents' quality of life. This study will integrate and expand on knowledge about social support and health-related quality of life of Korean American nursing home residents. The study findings will inform social work practice and help professionals who work with Korean Americans. Identifying the most important sources and types of social support for Korean American nursing home residents can help social workers intervene more effectively with them and their families. A better understanding of the relationship between social support and health-related quality of life issues of Korean American nursing home residents can facilitate programs and interventions that lead to more stable functioning of residents and their families.

The issues faced by ethnically diverse nursing home residents, including Korean Americans, in a health care setting are multiple and complex. Health care settings, such as nursing homes, hospitals, assisted living placements, health clinics, and adult homes,

are facing the challenges of understanding and supporting such residents and their unique needs. This study will serve to explore and expand knowledge about the Korean American elderly and their families. The findings of this study can then be used to identify and implement policy and program changes that may meet the needs of this emergent population. Finally, this study will provide a basis for further research on this population.

CHAPTER II. KOREAN AMERICAN ELDERS IN THE UNITED STATES

With the increased life expectancy and an increase in the population of elderly Korean-American immigrants, the need for nursing home care for this population is critical. Many Korean American elders need diverse health, personal, and social services for assistance with their daily life due to chronic physical, functional, or mental disabilities. However, compared to many other ethnic groups, their utilization of nursing homes is still limited, and this is largely due to their unique cultural values, beliefs, and attitudes. The 2000 Census reported that 1.4% of all Korean Americans aged 65 and over were living in nursing homes (Young and Gu as cited in Shin et al., 2002). The states with the largest percentages of Korean American elders living in nursing homes were California and New York.

There is insufficient information about the cultural patterns and life styles of Korean American elders and nursing home residents. This chapter presents knowledge which is important for a comprehensive and culturally sensitive approach for assessment that will increase understanding of Korean American elders and Korean American nursing home residents' special issues and needs.

Immigration History

Immigration of Koreans to the United States is a phenomenon of the twentieth century. The immigration history of Koreans in America has been charted by political and economic conditions in the United States as well as in Korea, racial dynamics in the

United States, and the very characteristics of the immigrants themselves (Hurh & Kim, 1984; Min, 1996; Park, 1997)

Korean immigration to the United States has occurred in three distinct waves: 1) the labor immigration to Hawaiian Islands (1902-1905); 2) the post Korean War immigration (1950-1964); and 3) the immigration after the Immigration Act of 1965 (Kitano & Daniels, 2001; Min, 2000; Shin, 1998). The initial immigration occurred between 1902-1905, when 7, 266 desperately poor farmers (all men) came to Hawaii as contract plantation laborers. This early labor immigration to Hawaii was stopped in 1905 due to pressure from the Japanese government (Min, 2000). After the Gentlemen's Agreement was signed between the United States and Japan in 1907, between 1910 and 1924 only Korean "picture brides" could be admitted to the U.S. (Min, 2000). Between 1924 and 1945, no Korean immigrants were admitted to the U.S. as the federal immigration laws legislated in 1924 completely barred immigration from Asian countries.

The second wave began around 1950 as a result of the Korean War. A significant number of Korean War orphans arrived as adopted children of American parents (Hurh, 1998; Hurh & Kim, 1984; Kitano & Daniels, 2001) and, about this time, Korean women married to U.S. servicemen in Korea began to immigrate in large numbers to the U.S. (Hurh, 1998; Hurh & Kim, 1984; Min, 2000). Between 1951 and 1964, approximately 6,500 brides, 6,300 adopted children, and 6,000 students came to the United States (Hurh, 1998; Hurh & Kim, 1984; Kitano & Daniels, 2001). These groups have been a significant component of the Korean immigration to the United States ever since. The number of

Koreans who have immigrated to this country as adopted children or brides of Americans since the Korean War reached more than 100,000 (Min, 2000).

The third wave of Korean immigration began with the passage of the U.S. Amendment to the Immigration and Naturalization Act of 1965, the Hart-Cellar Act, which ushered in a new era of racial and ethnic equality in American immigration policy (Hurh & Kim, 1984; Min, 2000). This Amendment opened the gates for Koreans and other Asian groups that had been severely restricted by previous quotas and gave legal preference to family reunification (Hooyman & Kiyak, 2008). As a result, for the first time Koreans were able to immigrate to the United States as families. Until this time, Korean immigrants were mostly individuals of special quality: laborers, students, picture brides, war brides, and orphans. Since that time, over 30,000 Koreans have immigrated annually, accounting for a tenfold increase in the Korean American population between 1970 and 1990. This rapid increase made Korean Americans visible to the American public as a distinct group, different from the Chinese or Japanese.

This most recent immigration cohort, primarily college degree professionals from the middle class of Korean society, is better educated than the previous two cohorts (I. Kim cited in Park, 1997). Due to lack of economic opportunities, unemployment problems, and political and social insecurity from the military dictatorship in Korea, many Koreans immigrated to the United States in the 1970s and the 1980s (Min, 1996, 2000).

The number of Korean immigrants admitted during the 1970s to 1980s grew exponentially, to 267,638. These Koreans constituted 6% of the total immigrants admitted to the U.S. in that decade, and were surpassed in number only by Mexicans and

Filipinos. Korean immigration peaked during the next decade of 1981 to 1990, constituting 4.6% of the total immigrants and ranking fourth after Mexico, the Philippines, and China. The 136,651 Koreans admitted between 1991 and 1998 represent 1.8% of the 7,605,068 immigrants admitted to the U.S. As a whole, a total of 778,899 Korean immigrants were admitted to the United States between 1941 and 1998. This number accounts for about three percent of the total immigrants admitted to the U.S. during this period (Min, 1998, 2000).

The majority of Korean American elders immigrated after the passage of the 1965 Immigration and Naturalization Act became effective in 1968 in order to join their adult children who came to the U.S after 1965 (Hurh, 1998; Hurh & Kim, 1984; Mui, 2001). This law allowed them to reunite with their families because they were granted visas under the family reunification category. Due to this immigration history, most Korean American elders immigrated and joined their adult children in the 1970s, and at that time were considered recent immigrants (Mui, 2001). According to the 2000 Census, 94% of Korean Americans aged 65 and older were not born in the U. S. (Korean American Coalition, 2003).

Throughout the years of Korean immigration to the United States, Korean American elders have been divided into two categories: 1) those who immigrated for occupational reasons when relatively young and independent and recently reached retirement age, so- called “immigrated elderly” (Min, 1998); and 2) those who immigrated to the United States after reaching the age of 50 and over at the invitation of their adult children who were already settled, so called “invited elderly” (Min, 1998). These two groups are very different in terms of their adaptation/assimilation to American

culture, dependence on their children, and resources (Cho, 2006; Min, 1998). The "immigrated elderly" have a longer U.S. work history and more resources than the "invited elderly" (Cho, 2006; Min, 1998). The "invited elderly" are least likely to be assimilated, least likely to have resources, and most likely to be unfamiliar with the American systems, including health care (Min, 1998; Olson, 2001). They are most heavily dependent on their adult children and the government for financial assistance (Min, 1998; Olson, 2001; Van Hook, 2000; Wong, Yoo, & Stewart, 2006).

The vast majority of Korean American elders in the United States are the "invited elderly" (Kim & Kim, 2001; Min, 1998). They often settle into domestic roles, including helping their adult children with child care and housekeeping tasks in the community (Min, 1998). They usually have limited education, limited English-speaking proficiency, and little or no work experience in the United States (Treas & Mazumdar, 2002). As a result, many are considered poor and are heavily dependent on family (Van Hook, 2000; Wong, et al., 2006).

Demographic Characteristics of Korean American Elders

As mentioned in the previous chapter, Korean Americans are one of the fastest growing populations, representing more than 10.3% of the total Asian American population in 2009 (U.S. Census Bureau, 2009). According to the 2009 Census, there were approximately 1.1 million Korean Americans in the United States, the fourth largest Asian American population after the Chinese, the Filipinos, and the Japanese (U.S. Census Bureau, 2009). Within this population, the proportion of older Korean Americans

has also increased; there were only 33,984 Korean Americans aged 65 or older, 4.3% of the total Korean American population in 1990; the number had grown to 68,505 by 2000, a 102% increase, constituting 6.4% of the Korean American population (Chee, 2004; Y. M. Lee, 2007; Mui, 2001; U.S. Census Bureau, 2000). When combined with the aging of many immigrants who came to the U.S. in the 1960s and 1970s, the older Korean American population is expected to continue to grow (Chee, 2004; Choi, 2001; Min et al., 2005; Mui, 2001). Due to Korean American elders' continued immigration, 7.6% of Korean Americans were aged 65 and over in 2009 (the corresponding figure for non-Hispanic Whites is about 14.5%) (U.S. Census Bureau, 2009).

The vast majority of Korean Americans residing in the United States are immigrants. Among all racial-ethnic groups, Korean Americans who are foreign-born constitute 82%, making them the Asian population with the second highest foreign-born elderly population (Min, 2000). It is also notable that over 30% of Korean American elders living in the United States immigrated after the age of sixty (U.S. Census Bureau, 2009).

Korean Americans tend to live in urban areas, with 96% residing in cities and only 4% in rural areas (U.S. Census Bureau, 2004b). Korean Americans tend to settle in the city where people from their country already reside, and this offers opportunities for new immigrants to learn about the new culture from relatives or friends who have already settled (Min, 2000). Korean American elders with language barriers prefer to stay in close contact with or live in a Korean community. Studies indicated that Korean American elders are usually located in large cities with Korean enclaves and tend to maintain their ethnic identity (Hurh, 1998; Hurh & Kim, 1984; Min, 2000). However,

Korean immigrants with children have a tendency to move to a white, middle class neighborhood after the initial acculturation process (Min, 2000).

More than 75% of all Korean Americans live in 10 states: California, New York, New Jersey, Illinois, Washington, Texas, Georgia, Maryland, Hawaii, and Pennsylvania (U.S. Census Bureau, 2004b). About forty-five percent of all Korean Americans reside in the West and 24% live on the east Coast (U.S. Census Bureau, 2004b). The states with the largest percentages of Korean Americans as a proportion of the state population are California (33%), New York (12%), and New Jersey (5%). However, the states with the fastest growing emerging Korean American populations based on highest growth rates from 1990 to 2000 were Georgia (88.2%), Nevada (75.1%), North Carolina (73.4%), New Jersey (69.6%), Tennessee (64%), Washington (57.9%), Arizona (55.6%), Florida (54.3%), and Virginia (50.1%) (Korean American Coalition, 2003).

Regarding educational attainment and financial well-being, Korean Americans have the third highest percentage of high school graduates (78%) but their per capita income is almost 25% less than the national average (Min, 2000). While many Koreans are well-educated (most of their educational training having occurred in Korea), the large proportion of foreign-born among them implies that many must cope with English as a second language. This obstacle and the difficulty of translating educational attainment in Korea into similar credentials in the U.S. have resulted in relatively large numbers of them being underemployed. Several studies on Asian American elders conducted in the New York City area showed that 87% of Korean American elders were high school graduates but the median household income for Korean American elders was in the $6,000 -$8,500 range (Cross, 2003; Mui, Nguyen, Kang, & Domanski, 2006, Mui et al.,

2007). Studies also indicated that the proportion receiving poverty-based income supplements was high (64%) for Korean American elders (Mui et al., 2006, 2007). Comparing studies of Chinese and Korean American elders, Korean American elders were less likely to receive Medicaid (38.1%) than Chinese American elders (58.3%) (Mui et al., 2007).

In terms of their English language proficiency, several studies report self-reported ability to speak English was "not too well" or "not at all" for 89% of Korean American elders (Cross, 2003; Mui et al., 2006, 2007). According to the studies on demographic profiles of Asian American elders in New York City, 47% of Korean American elders reported no ability to read and 45% could not write in English (Mui et al., 2006, 2007). Fewer than 4% of Korean American elders reported an ability to write and read English "very well." (Mui et al., 2006, 2007). A study of 95 elderly Korean immigrants in Los Angeles found that about 85% of the sample reported problems with speaking English, and about 93% reported problems with reading and understanding English (Lee et al., 2004). These findings pointed out that the majority of Korean American elders are severely disadvantaged in their ability to negotiate life outside the local community where the native language may be predominant (Mui et al., 2006, 2007).

Views of Family Relationships: Filial Piety and Intergenerational Relationships

Relationships within Korean families provide some background for understanding cultural patterns of aging, elderly living arrangement, and family support. In the Korean culture, the importance of family is a core social value, and family solidarity and mutual

dependence among family members are encouraged (Kim, 1995, Y. M. Lee, 2007, Pang, 1998; Sung, 1995, 2000). At the core of the family system is respect for elders and filial piety. Elders are valued for their wisdom in the family; they are consulted for support, advice, and resolution of family conflicts (Kim, 1995; Pang, 1998; Sung, 1995, 2000). Filial piety based on Confucian norms can be defined as the expression of responsibility, respect, and family harmony that dictates children's attitudes, roles, and responsibilities toward family-based support (Ishi-Kuntz, 1997; Kim, Kim, & Hurh, 1991; Pang, 1998; Sung, 1995, 2000). Filial piety particularly stresses that aged parents deserve the most careful attention due to children's indebtedness to their parents for giving birth to them and rearing them (Ishi-Kuntz, 1997; Kim, 1995; Y. M. Lee, 2007). From this perspective, adult children have a moral obligation to support their elderly parents (Ishi-Kuntz, 1997; Kim & Kim, 2001; Kim et al., 1991). Filial piety persists in the households of Asian immigrants, as evidenced by the many petitions of newly settled immigrants to bring their aging parents to the United States (Ishi-Kuntz, 1997; Kim, 1995; Lee, 2007).

Some studies indicated that the traditional family values of supporting elderly parents continue even when people immigrate to a new society (Ishi-Kuntz, 1997; Kamo & Zhou, 1994). The studies reported that elderly immigrants who came to the United States at older ages were heavily dependent emotionally and financially on their adult children and were more likely to live with them to receive physical, emotional, and financial support. Those studies concluded that Asian American elders, including Chinese and Koreans, prefer to live with their adult children, which is considered as a cultural preference (Ishi-Kuntz, 1997; Kamo & Zhou, 1994).

On the other hand, Lee and Mock (2005) addressed common modifications that occur in Asian American families, including Korean American families: 1) fewer multigenerational families and more nuclear families; 2) erosion of the patriarchal family structure,; 3) an increase in bilateral family structure; 4) women participating in the labor market; and 5) equal importance placed on sons and daughters. Several studies reported changes in family values of co-residence and family support, and indicated that traditions of filial obligation are challenged by the realities of life in the United States (Cheung, 1989; Lam, Pacala, & Smith, 1997; Wong et al., 2006; Yoon, Eun, & Park, 2000). In other words, strong family ties and support within family members based on filial piety do not seem to insure Korean American elders' successful adjustment to the U.S. (Treas & Mazumdar, 2002). Influenced by a new culture, traditional family values may no longer be followed by the adult children. In addition, elders may experience devalued status in their family and diminished influence over their children (Cheung, 1989; Koh & Bell, 1987). One study examining the status of older Korean immigrants and their changing roles in their families showed that older Korean American immigrants are not regarded as playing a prestigious and important role in the family (Kauh, 1999). Due to their changing or reversing roles, they have a tendency to view themselves as useless and powerless after coming to the United States (Y. M. Lee, 2007). Moreover, other studies pointed out that filial piety has been weakened in Korean American families in the U.S. due to the changed economic circumstances following immigration to the U.S., in which both their adult children and in-laws are employed in order to support the family (Kim & Kim, 2001; Song, 1998; Wong et al., 2006; Yoon et al., 2000). A great majority of Korean immigrant wives are employed and make a substantial contribution to the

financial resources of the family households (Kauh, 1999; Wong et al., 2006). Such a contribution provides wives with power and higher status in their family (Kauh, 1999; Kim et al., 1991; Wong et al., 2006). Daughters-in-law, who were once considered the primary caregivers to older parents, are no longer obligated to fulfill their filial piety duty as the ideal patrilineal structure of traditional family is giving way to a bilateral emphasis (Kauh, 1999). Several studies demonstrated that the current conditions of immigrant life, including the changed economic and social structure, make the traditional filial piety expectation of elderly Koreans difficult to maintain (Choi, 2006; Kim & Kim, 2001; Wong et al., 2006; Yoon et al., 2000).

However, much evidence has suggested that the traditional expectation of filial piety is still embedded in the cultural belief system among Korean immigrant families. As a result, Korean immigrants currently encounter a great deal of difficulty resolving the conflicts of intergenerational relationships between elderly parents and married children/spouses (Choi, 2006; Kauh, 1999; Kim & Kim, 2001; Y. M. Lee, 2007; Wong et al., 2006; Yoon et al., 2000). Furthermore, incongruities between Korean American elders' values and the reality of their lives in a new culture are very stressful and full of conflict for Korean elders (Kauh, 1999).

Because of Korean American elders' changing roles in the family and a gap between the traditional expectations of Korean American elders and the financial capacity of their adult children, Korean American elders prefer to live independently (Choi, 2006; Kim & Kim, 1997; Y. M. Lee, 2007; Yoo & Sung, 1997). Their preference for a separate household from their children is considered contrary to the traditional living arrangement, in which the married eldest son is expected to live with his older

parents in the community. One study reported that co-residence of Korean American elders in the United States with their children has declined from about 75% in 1980 to 57% in 1990 (Yoo & Sung, 1997). According to Mui and Shibusawa's recent study (2008), the proportion of Korean American elders (50.5%) who believe that their adult children should live with them was lower than the proportion of elders in any other Asian group, including Chinese (69.7%), Filipino (66.7%), Japanese (88%), Indian (96.6%), and Vietnamese (92%). Another study demonstrated that Korean American elders also tend to accept the mainstream American values they have been exposed to, including the nuclear family, independent living and self support (Y. M. Lee, 2007).

Religion and Spirituality

In recent years, several studies have paid attention to how religion influences different aspects of physical and mental health (Chang, Noonan, & Tennstedt, 1998; Ellison, 1991; Idler & Kasl, 1992, 1997; Koenig, 1994; Koenig, Hays, George, Blazer, Larson, & Landerman, 1997; Koenig, McCullough, & Larson, 2001; McCullough & Larson, 1999; Pang, 1996; Stuckey, 2001). One study showed that religion has a positive influence in overall health (Matthews, Larson, & Barry, 1993). Another study pointed out that religious involvement contributes to individuals' psychological well-being and subjective perceptions of quality of life (Ellison, 1991). Ellision's study (1991) indicated that individuals with strong religious beliefs report positive psychological conditions, including higher levels of life satisfaction and greater happiness. Moreover, some studies identified religion as a significant coping resource during stressful life events (Ai,

Dunkle, Peterson, & Bolling, 1998; Chang et al., 1998; Idler, 2002; Pang, 1996, 2007; Pargament, 1998; Picot, Debanne, Namazi & Wykle, 1997; Stuckey, 2001). They highlighted that religious involvement may prevent potentially risky coping behaviors and help people to cope with illness.

Findings of empirical studies pointed out that religious involvement is positively associated with better morale, stronger coping skills, and better physical and mental health among elderly individuals (Fabricatore, Handal, & Fenzel, 2000; Fry, 2000; Ilder & Kasl, 1992; Koeing et al., 1997; Koeing & Larson, 1998; Levin & Chatters, 1998). For example, one study found that depression and alcohol abuse are less prevalent in religious older adults (Zucker, Fair, & Branchley, 1987). Hypertension and cardiac problems are influenced by religious behaviors (Johnson, 1995; Krause 1991; Levin & Markides, 1985). Koeing and colleagues (1997) suggested that religious involvement may increase one's perceived health status and act as a buffer against the negative impact on medical problems. Among chronic care nursing home residents, participants who exercised religion to cope had greater social support and better cognitive functioning, despite more serious medical problems (Koenig, Weiner, Peterson, Meador, & Keefe, 1997). Religious involvement is also positively correlated with an array of subjective well-being indicators, including greater life satisfaction, decreased depressive symptoms, less anxiety, and better emotional adjustment among older adults (Koenig et al., 2001; Kraaij, Garnefski, & Maes, 2002; E. O. Lee, 2007; McFadden, 1995; Morris, 1997; Park, Roh, & Yeo, 2011; Yoon & Lee, 2004, 2007). Some studies found that religious people appear to have increased exchanges of assistance, increased social contact, and greater perceptions of support adequacy and availability (Bradley, 1995; Krause, 2002).

Although a considerable body of research suggested that religion and its practice are associated with better mental health and individuals' subjective well-being (Ellison, 1991; Koenig et al., 1997; Koenig et al., 2001; E. O. Lee, 2007; Matthews et al., 1993; McCullough & Larson, 1999; Stuckey, 2001; Yoon & Lee, 2004, 2007), several studies pointed out that the role of religion in protecting older adults against mental health problems is still unclear (Atchely, 1997; King, Weich, Nazroo, & Blizard, 2006; Strawbridge, Shema, Cohen, Roberts, & Kaplan, 1998). In a longitudinal study examining the importance of being religious and its influence on health and psychological well-being over a 14-year period, Atchely (1997) failed to find longitudinal effects of religion on mental health. Another study reported an inverse association between organized religiosity and depression (Strawbridge et al., 1998). In addition, King and his colleagues (2006) reported that there was no difference in prevalence of mental health problems between people who were religious and those who were not.

Religion and spirituality are broad terms that incorporate many meanings. Older adults may associate the term religion with a variety of meanings and may include a range of spiritual aspects (Nelson-Becker, 2005), and they may use the terms religion and spirituality interchangeably (Hill & Pargament, 2003; Kendler, Liu, Gardner, McCullough, Larson, & Prescott, 2003; Yoon & Lee, 2004). However, several studies pointed out that the constructs of religion and spirituality are complicated and may be conceptually overlapping, but they are not the same (Emmons & Paloutzian, 2003; Hill & Pargament, 2003; Wink & Dillon, 2003). Fundamentally, religion is defined as a community's formalized and institutionalized pattern of beliefs, values, symbols,

behaviors, and spiritual values (Canda & Furman, 2010; Nelson-Becker, 2005). In general, religion encourages moral standing and participation in activities that attest to a belief in God or a higher power (Emmons & Paloutzian, 2003). On the other hand, spirituality refers to an essential quality of human beings and human process that involves seeking the meaning and purpose of life (Canda & Furman, 2010). It also refers to a range of experiences that embrace the existence of God or a higher power without requiring the actual practice of, or participation in, organized religious activities (Emmons & Paloutzian, 2003). Spirituality is related to morality and values, a sense of the transcendent and connectedness to others, and other transpersonal experiences that are not necessarily connected to a certain religion (Canda & Furman, 2010; Delgado, 2005; Pargament, 2007).

The literature from several studies indicated that most immigrants continue and/or rebuild their religious and/or spiritual lives in their new country (Ai et al., 1998; E. O. Lee, 2007; Lee & Chan, 2009; Min & Kim, 2002; Mui & Kang, 2006; Pang, 1996, 2007; Yoon & Lee, 2004, 2007). Some studies demonstrated that religious-based communities provide a distinct cultural, linguistic, and ethnic identity and reinforcement (Levitt & Schiller, 2004; Mui et al., 2006; Pang, 1996, 2007; Wolfe, 2003). Religious congregations also help immigrants integrate in American society by providing a connection to groups that mediate between the immigrant and the host society (Pang, 1996, 2007; Wolfe, 2003). Religious congregations enable immigrants to maintain and promote ethnic identity while simultaneously acquiring community acceptance (Yang & Ebaugh, 2001).

Several studies indicated that most Korean American elders in the U.S. have a religious affiliation, including Buddhism, Catholicism, or Protestantism (Chang & Moon, 1997; E. O. Lee, 2007; Moon, Lubben, & Villa, 1998; Mui et al., 2006; Pang, 1996, 2007). In general, most Korean Americans in the U.S. are Protestant Christians (Lee et al., 2004; Mui, 2001). One study reported that 77% and 14% of Korean American elders in the U.S. were Protestant and Catholic, respectively (Chang & Moon, 1997). Among Asian American elders residing in metropolitan areas, nearly half the Korean elders from the study were Protestant and one-quarter were Catholic (Mui et al., 2006). According to the 2008 Korea Daily Business Directory of New York, published by a Korean newspaper company, there were 460 Protestant churches, 15 Catholic churches, and 27 Buddhist temples in New York alone (The Korea Daily, 2008). It roughly estimated a ratio of one religious organization for every 200 Koreans in New York. In fact, many recent studies indicated that 77%-97% of Korean American elders are closely affiliated with Korean religious organizations and report a moderate to high level of religious experiences (E. O. Lee, 2007; Min et al., 2005; Roh, 2010).

One study explored three important functions of the Korean ethnic religious organization (Hurh & Kim, 1990b). First, it functions as a social network and a means of cultural identification (in terms of language and traditional values). Second, it serves an educational function by teaching American-born Koreans the Korean language, history, and culture. Third, the church preserves Korean nationalism. In addition, ethnic religious organizations not only provide useful information about health care, education, and housing, but also offer pastoral counseling, family counseling, and advice to individual

members who are psychologically distressed or in the midst of a crisis (Kwon, 2000; Min, 1992).

In terms of the Korean elders' spirituality, one study reported that seventy-one percent of the Korean elders felt their religion was "very important", and less than fifteen percent considered their religion as "not important" (Mui et al., 2006). Among Korean elders, more than 70% reported attending religious services weekly or more while 20% reported never attending a religious activity (Mui et al., 2006).

The effects of religion may be different among Korean American immigrants. In a study of the Korean Protestant church, Hurh and Kim (1990b) analyzed the religious participation patterns of 622 adult Korean immigrants. They argued that religious needs, psychological needs, and social needs for attending church were inseparable among Korean American immigrants. They also found that the majority of respondents actively participated in church functions regardless of their length of residence, level of education, economic status, age, gender, or socio-cultural assimilation.

One study pointed out that religion has a role in strong social development and interaction among people in the community (Pang, 1996). Korean churches in the U.S. play an important role for Korean American immigrants, not only for providing religious and spiritual support, but also for providing social service information and cultural activities (Choi & Tirrito, 1999; Kim, et al., 1997; Min, 1992; Tirrito & Choi, 2004). In other words, Korean American churches are one of the most important organizations in the community, as Korean American immigrants can develop informal social ties with other Korean Americans, as well as receive information on coping strategies for adjusting

to a new environment (Choi & Tirrito, 1999; Kim et al., 1997; Min, 1992; Tirrito & Choi, 2004).

Although very few empirical studies have been conducted to examine the importance of religion/spirituality to Asian American elders, one study found support for the importance of religion within Asian American communities, as a majority of elders believed that religion is very important in their lives (Mui et al., 2006). Another study examined religion and spirituality as predictors of well-being among Chinese and Korean American elders (E. O. Lee, 2007). This study reported that utilization of religious coping skills was associated with greater life satisfaction among Asian American elders (E. O. Lee, 2007). Findings of this study also suggested that religious support can be a potential protective indicator in alleviating depressive symptoms and improving life satisfaction for elderly Korean and Chinese Americans who face difficulties in coping with acculturation stress, bereavement, health challenges, and diminishing social resources (E. O. Lee, 2007). A study on the similarities and differences in religion and spirituality, and the degree of depression among elderly Korean American women in Washington D.C., interviewing 19 participants over 70 years old, found that not a single study participant was depressed (Pang, 2007). With a sample of 200 elderly Korean immigrants in New York City, Park and his colleagues (2011) found that greater religiosity was related to greater life satisfaction. In addition, their study findings indicated that religious engagement could be a significant factor to improve quality of life among Korean American elders (Park et al., 2011).

Physical and Mental Health Status among Korean American Elders

Physical Health Status

The prevalence of chronic health conditions varies by race and ethnicity in the older population. In one study (Mui, 2003) conducted in New York City, over half of the Asian American elders reported that their overall level of health was either excellent (24%) or very good (31%). Mui's study (2003) pointed out that the most prevalent medical conditions among Asian American elders are arthritis (43.4%), high blood pressure (41.5%), high cholesterol (28%), cataracts (26.7%), and diabetes (17.5%). In addition, Mui's study (2003) indicated that when compared to the general elderly population, Asian American elders report higher rates of hypertension (41.5% versus 38%), cataracts (27.7% versus 16%), and diabetes (17.5% versus 9%). However, the prevalence of arthritis (43.4%) is lower among Asian American elders compared to the general population (48%). Mui (2003) also found that Asian American women are more likely to have osteoporosis (9.5% versus 3.6%), anemia (9.9% versus 4.8%), and arthritis (30.8% versus 12.5%) than men.

Compared to other Asian American elders, Korean American elders in New York City are more likely to have arthritis, high blood pressure, and osteoporosis (Mui, 2003). Other studies indicated that most Korean-American elders are more likely to report having arthritis, hypertension, heart disease, and stroke than either non-Hispanic white persons or Hispanic persons (Lee et al., 1993; Mui, 2001; Mui & Shibusawa, 2008). One study reported that Korean-American elders have a higher prevalence of diabetes, which is four times the rate of older Americans in general in the Unites States (Lee et al., 1993).

However, it was reported that compared to White elders, Korean American elders show a lower frequency of heart disease and stroke, and all risk factors including high blood pressure, high levels of cholesterol, current smoking status, and physical inactivity (Lee et al., 1993). Another study found that Korean American elders experienced significantly higher levels of cardiovascular disease than their White counterparts (Kim et al., 2001). From a cross-sectional epidemiological study of high blood pressure among Korean American elders in Maryland, a significantly high prevalence of high blood pressure (32%) was reported, as compared with 24% among older Americans in general (Kim et al., 2000).

Among chronic health conditions, Korean-American elderly women are more likely to report having arthritis but less likely to report having heart disease compared to Korean-American elderly men. In addition, Korean-American men are also more likely to have had cancer compared with Korean-American women (Lee et al., 1993). Another study also reported that high blood pressure is more common in Korean American elderly men (35%) than in females (30%) (Kim et al., 2000).

One study showed that there are major differences in patterns of health risk between Korean elders in Korea and Korean-American elders (Shin et al., 2002). According to this study, circulatory disease, including hypertension and coronary heart disease, and cancer are the two major health problems of Korean elders in Korea. On the other hand, Korean-American elders report a higher prevalence of diabetes than Korean elders in Korea. They also report a higher risk of hypertension and cardiovascular disease.

In terms of self-rated (perceived) health status, a recent study conducted in the New York City area found that more than two thirds of the Korean American elders (72%) reported their general health was “fair or “poor” (Mui & Shibusawa, 2008). Another study conducted in Los Angeles using a probability sampling method reported that Korean American elders, compared with non-Hispanic Whites, perceived their health to be poorer and reported higher rates of arthritis, kidney disease, hypertension, and functional limitation (Villa et al., 1997).

Mental Health Status

Depression

Several studies have reported a higher prevalence of depression among immigrant populations when compared with dominant cultural groups (Aroian & Norris, 2003; Cuellar, Bastida, & Braccio, 2004; Gonzalez, Haan, & Hinton, 2001; Min et al., 2005; Wilmoth & Chen, 2003). The combination of the rapid changes and challenges in life, including economic, political, social, cultural, and familial, appears to increase immigrants’ susceptibility to depression and other psychological distress (Heilemann, Frutos, Lee & Kury, 2004; Jang et al., 2005a; Lee et al., 2004; Min et al., 2005; Mui, 2001; Shen & Takeuchi, 2001; Wong et al., 2007). The psychological impact of immigration may be even greater among older immigrants who migrate later in life than those who do so in young adulthood, because they have limited resources in coping with the multiple losses associated with the process of adaptation and acculturation, poor health, lack of family support, social isolation, and language barriers (Chee, 2004; Han et al., 2007; Kang, Domanski, & Moon, 2009; Lee et al., 1996, 2001; Min et al., 2005; Mui,

1996, 2001; Mui & Kang, 2006; Mui et al., 2007; Pang, 1996; Wong at al., 2007; Yamamoto et al., 1994).

Although the literature focusing on depression among Korean American elders is limited, a few available studies have demonstrated that the majority of Korean American elders may experience high levels of depression (Chee, 2004; Han et al., 2007; Hurh & Kim, 1990a; Jang et al., 2005a, 2005b, 2007; Kim et al., 2005; Koh, 1998; Kuo, 1984; Lee et al., 1996, 2004; Min et al., 2005; Mui, 2001; Mui & Kang, 2006; Pang, 1995; Yamamoto et al., 1994).

In an earlier study of depression among 449 Asian Americans in Seattle, Kuo (1984) found that Korean American elders experienced higher levels of depression than other Asian Americans. One study shows that older Korean-Americans and older whites are at similar risk for depressive symptoms (Yamamoto et al., 1994). Another study suggested that depressive symptoms among elderly Korean-Americans are much higher than among elderly Chinese-Americans (Mui, 2001). This study also reported that older Korean women are more vulnerable to depressive symptoms than are older Korean men. Moreover, a recent study examining depressive symptoms using the two standard measures of depression, the Geriatric Depression Scale (GDS-SF) and the Center for Epidemiologic Studies-Depression Scale (CES-D), with 230 Korean American elders in Florida reported that Korean American elders manifested relatively more symptoms of depression (Jang et al., 2005a). Furthermore, a study using data from a two-wave panel survey of 172 Korean American elders and 157 non-Hispanic White elders in Southern California found that older Korean immigrants reported a higher level of psychological distress than the non-Hispanic White elderly at both time-points (Min et al., 2005).

Several other studies further investigated depression and its correlates and effects for Korean American elders (Kim et al., 2005; Kuo, 1984; Lee et al., 1996; Min et al., 2005; Moon, 1996; Mui, 2001). Other psychological constructs, including alienation and morale among Korean American elders, were also examined (Moon, 1996; Moon & Pearl, 1991). Significant correlates of depression included shorter length of residency in the United States (Jang et al., 2007; Moon & Pearl, 1991), lower levels of acculturation (Jang & Chiriboga, 2010; Jang, et al., 2005a, 2007; Lee at al., 2004; Moon & Pearl, 1991; Mui & Kang, 2006; Mui et al., 2007), poor self-assessed health and functional limitation (Lee et al., 2004; Min et al., 2005; Moon, 1996; Mui, 2001; Mui et al., 2007), limited social activities (Choi, Wilbur, Miller, Szalacha, & McAuley, 2008; Jang & Chiriboga, 2011; Yang, Laffrey, Stuifbergen, Im, May, & Kouzekanani, 2007), and lack of family support and family relationships (Kim et al., 2005; Lee et al., 1996, 2004; Min et al., 2005; Moon, 1996; Moon & Pearl 1991; Mui, 2001).

In terms of gender variations in depressive symptoms, one recent study examined gender differences in depression among older Korean immigrants using a community sample of 230 older Korean immigrants in Florida (Jang et al., 2011). Consistent with previous literature on gender and depression (Blazer, Kessler, McGonagle, & Swartz, 1994; Kessler, 2003; Li, Liang, Toler & Gu, 2005; Nolen-Hoeksema, Larson, & Grayson, 1999), Korean elder women were found to score higher on depressive symptoms than men. In addition, Korean elder women and those with more chronic health conditions, greater functional disability, and lower sense of control and acculturation were found to have more depressive symptoms (Jang et al., 2011).

Depression in the Korean Context

Depression, or *woo-ul-jeuing* in Korean (Yi, 1990), is defined as a condition in which one's self is out of balance (Shin, 2010). In other words, Korean Americans consider depression, *woo-ul-jeuing*, as a lack of balance or disharmony among the body, mind, and environment (Shin, 2010). A recent study (Shin, 2010) with a convenience sample of 70 Korean American immigrants in New York City found that participants described their depression as manifested through the feeling of an "unbalanced self."

For Korean American elders, somatic complaints and distress are the most common expression of depressive symptoms, not only because they represent a more acceptable means of expressing psychological disturbance (Chun et al., 1996; Kim, 1985; Lee et al., 2001), but also because this is more culturally acceptable (Mui, 1996; Pang, 1996). Societal factors such as the stigmatization of mental illness make it more acceptable for psychological distress to be expressed as body rather than mind ailments (Chun et al., 1996; Lee et al., 2001; Pang, 1995, 1996). As a result, Korean American elders may have difficulty in differentiating clearly whether they suffer from a physical or a mental illness (Lee et al., 2004; Shin 2010).

As evidence of somatization in Korean American elders, *hwa-byung* is a culturally recognized and accepted expression of one's psychological and physiological status (Chun et al., 1996; Lee et al., 2001; Pang, 1995). *Hwa-byung*, the expression of psychiatric disorders, is an indicator of mental illness associated with the suppression of anger. Common symptoms related to *hwa-byung* include fatigue, insomnia, panic, generalized pain and aches, and fear of impending death (Chun et al., 1996; Lee et al., 2001; Pang, 1995). The most unique aspect of this *hwa-byung* is that Koreans label

themselves as having this “illness”, which develops into clinical depression, anxiety, or somatic symptoms (Chun et al., 1996; Lee et al., 2001; Pang, 1995).

Depression and Help-Seeking Behaviors

Despite substantial prevalence rates, symptoms of depression are often unrecognized, undiagnosed, and even untreated due to cultural factors (Jang, Chiriboga, & Okazaki, 2009; Jang et al., 2005b; Lee et al., 2004; Mui, Burnette, & Chen, 2001; Pang, 1995). Several studies pointed out that many members of ethnic minority groups, including Korean American elders, have not utilized or benefited from the use of mental health services due to their cultural norms and beliefs (Jang et al., 2005b, 2006a; Lee et al., 2001; Mui, 1996; Mui & Kang, 2006; Mui et al., 1998; Park & Bernstein, 2008; Shin, 2010; Snowden & Cheung, 1990).

Several studies pointed out that Korean Americans are considered as a collective-based community (Kim, Kleiber, & Kropf, 2001; Lee et al., 2001; Park & Bernstein, 2008). Therefore, studies suggested that the majority of Korean Americans strongly believe that problems should be resolved within the family (Lee et al., 2001; Park & Bernstein, 2008; Shin, 2010). Research has also shown that most Korean Americans attempt to control negative emotions and distress through personal will-power, believing that emotional difficulties are temporary (Jang et al., 2006a; Lee et al., 2001; Park & Bernstein, 2008; Shin, 2010). In other words, cultural factors include the fact that Korean American elders prefer to resolve problems on their own before seeking assistance from others, and they tend to regulate emotions internally instead of expressing them publicly (Chun et al., 1996; Lee et al., 2001; Pang, 1995).

For Korean Americans, mental illness is perceived and stigmatized as deviant behavior (Choi, 2001; Mui, 2001; Pang, 1996). A recent study examining the attitude toward mental health services with a sample of 209 younger and 462 older Korean Americans found that depression is seen as a sign of personal weakness and brings shame to the whole family (Jang et al., 2009). Because of culturally fostered shame and stigma against mental illness, Korean Americans are generally reluctant to seek professional help until their illness becomes severe and serious (Choi, 2001; Kang & Kang, 1995; Kim, 1985; Mui, 2001). They are more likely to seek services from herbalists, acupuncturists, or primary care physicians (Shin, 2010). A recent study with an exploratory survey of 205 Korean Americans found that most respondents tended to seek advice about their mental health problems from non-mental health professionals, including physicians, friends, or religious healers (Cheung et al., 2011). The findings also suggested that the majority of Korean Americans did not acknowledge the importance of psychological counseling or accept early interventions from mental health professionals (Cheung et al., 2011). Pang (1996) reported that there is relatively little evidence that elderly Korean-American immigrants have received mental health services in the community or that they use antidepressants.

A more recent study (Jang et al., 2007) with a sample of older Korean Americans (N = 472) in Florida found that despite their high levels of depressive symptoms, only 6.5% of the sample reported that they had previously contacted mental health professionals. This study also revealed that more than half (51%) reported depression as a normal part of aging, approximately 71% perceived depression as a sign of personal weakness, and 14% reported that having a mental illness brought shame to the whole

family (Jang et al., 2007). Other studies also demonstrated that they believe that one can avoid depression by being religious and flexible, and by keeping busy and talking with friends and family (Hyun, 2001; Kim, 1985; Pang, 1995, 1996).

Depression and Social Support

Social Support has been a significant factor affecting an immigrant's mental health (Han et al., 2007; Mui & Shibusawa, 2008; Wong et al., 2005, 2007). Researchers have studied the role of social support and its impact on the psychological well-being of Korean American immigrant elders (Han et al., 2007; Hurh & Kim, 1990a; Min et al., 2005; Moon & Pearl, 1991; Mui, 2001; Wong et al., 2005, 2007). For instance, an epidemiological study of Korean immigrants identified that social networks around ethnic churches are positively associated with the immigrant's mental health (Hurh & Kim, 1990a). Another study found that living with a spouse protected against feelings of alienation for Korean American elders (Moon & Pearl, 1991). In their study, the effect of living with children was not statistically significant. Wong and her colleagues (2007) examined social support and psychological well-being in older Chinese and Korean immigrants. A study using a convenience sample of 200 self-identified Chinese and Koreans aged 65 and over found that those who lived with their spouse and adult children had lower overall psychological well-being and lower positive affect compared to those who lived alone (Wong et al., 2007). In addition, the study findings suggested that older Koreans' psychological well-being may be negatively afftected when they live with their adult children.

A study using data from a two-wave panel survey of 172 Korean American elders and 157 non-Hispanic White elders in Southern California found that social support, such as social and familial factors, were significant in accounting for decreases in psychological distress for Korean American elders, but not for the non-Hispanic White elders (Min et al., 2005). This study also identified that perceived social support had significant temporal and time-lagged effects on psychological distress.

Recent studies reported that fewer family contacts and a smaller social network are associated with higher depression (Han et al., 2007; Lee at al., 1996, 2004; Mui, 2001). A study of 95 Korean American elders in Los Angeles found that greater positive support from the family, and good family relationships, were significantly associated with decreased depression (Lee et al., 2004). This study further reported that Korean American elders' perceptions of their relationship with their adult children proved to be significantly associated with their level of depression. In other words, this finding indicated that conflict in family relationships is an important risk factor for depression. Mui (2001) also found a similar result in examining stress, coping, and depression of 67 older Korean immigrants. In this study, it was found that Korean American elders received a considerable amount of emotional and instrumental support from their adult children and that the quality of their relationship with family was a protective factor that mitigated depressive symptoms. In other words, perceived satisfaction with the quality of their support from family was identified as a significant negative predictor of depression among Korean American elders (Mui, 2001).

A secondary data analysis of a survey of 205 Korean American elders reported that higher appraisal of social support was predictive of lower depressive symptoms (Han

et al., 2007). In this study, adult children were found to be the most common source of support, regardless of the type of need (Han et al., 2007). However, this study did not find a statistically significant association between the size of a person's network and their level of depression. This finding is inconsistent with the report by another study (Lee et al., 1996), which suggested that network size was a positive predictor in individual psychological health in Korean American immigrants.

Utilization of Formal Services among Korean American Elders

Health and Mental Health Service Utilization: Barriers and Issues

Although Korean American elders appear to experience multiple physical and mental health problems, they have generally low rates of utilization of health services or mental health services (Choi, 2001; Jang et al., 2005b, 2007; Lee et al., 2001; Mui & Shibusawa, 2008; Mui et al., 1998;; Shin, Kim, Juon, Kim, & Kim, 2000). The under-utilization of health care services by Korean American elders has been attributed to language barriers and cultural differences (Choi, 2001; Jang et al., 2005b, 2007; Mui, 2001). Their lack of language skills restricts potential service recipients' exposure to necessary information on available health care services (Choi, 2001; Jang et al., 2005b, 2007; Mui, 2001). Cultural factors, including a belief that services based on a Western model of wellness are irrelevant, are powerful inhibitors to these elders' seeking external help (Choi, 2001; Jang et al., 2005b; Lee & Sung, 1998). Cultural beliefs and attitudes also affect perceptions of the problems and modalities available for treatment of the problems of physical illnesses or mental disorders (Choi, 2001; Lee & Sung, 1998). In

addition, lack of cultural sensitivity and competence on the part of service providers from the dominant culture has generated distrust of the entire formal health service industry by Korean Americans (Choi, 2001; Mui, 2001). In sum, culturally driven health beliefs, language barriers, coping mechanisms, and attitudes toward use of formal services among Korean American elders influence utilization of services (Min & Moon, 2006).

Although cultural and other factors are indeed significant barriers to utilization of formal health services by Korean American elders, various institutional and socio-structural barriers to service utilization also exist (Choi, 2001; Lillie-Blanton & Hudman, 2001; Min & Moon, 2006). They include service eligibility restrictions for legal immigrants, as well as for undocumented immigrants, lack of awareness of formal services, the stereotype that Korean American elders are taken care of by their families, and lack of culturally sensitive and appropriate services. For example, studies indicate that Korean American elders may not receive services because they are not allowed to do so under governmental policies and regulations (Choi, 2001; Lillie-Blanton & Hudman, 2001). Since government policies regarding health insurance can influence services and hamper accessibility, government policy has adversely affected immigrants' ability to obtain health coverage and, thus, access to care (Lillie-Blanton & Hudman, 2001). In other words, lack of health insurance coverage is a major issue facing Korean-American elders. Several studies have shown that Korean American elders are less likely to have health insurance that whites (Jang et al., 2005b; Pourat, Lubben, Yu, & Wallace, 2000; Sohn & Harada, 2004;). For instance, a study assessing healthcare utilization of older Korean Americans found that more than one-quarter of the study sample (N = 230) was uninsured (Jang et al., 2005b). Another study using a sample of 208 Korean Americans

aged 64 and older in Los Angeles indicated that 78% were insured and those who were uninsured had about 40% fewer physician visits than those who were insured (Sohn & Harada, 2004).

Long-Term Care (LTC) Service Utilization

Several studies found that immigrant elders have been found to use long-term care services less than their non-Hispanic White counterparts, relative to their higher level of functional limitations (Damron-Rodriguez, Wallace, & Kingston, 1995; Moon et al., 1998; Mui & Burnette, 1994; Mui et al., 1998; Wallace, Campbell, & Lew-Ting, 1994; Wallace, Levy-Storms, Kingston, & Andersen, 1998). The underutilization of long-term care services among minority elders is attributed to cultural norms, strong family and community networks, discrimination, and barriers to access due to language barriers and low socioeconomic status (Mui & Burnette, 1994; Mui et al., 1998; Wallace, 1990; Wallace et al., 1998). One study suggested that traditional norms in Asian countries, including familism and filial piety, have contributed to the reluctance to use long-term care and served as a major obstacle to service utilization (Kim & Kim, 2004).

Several studies reported that some Korean American elders face great challenges in dealing with long-term care in the United States due to cultural discontinuity, weakening social support networks from family and breakdown of filial piety, and their diminished roles and status within family (Lee et al., 1996; Moon & Pearl, 1991; Yamamoto et al., 1994; Yu, Kim, Liu, & Wong, 1993). Another study indicated that extremely low levels of awareness and knowledge of available community long-term care services may signify their challenges (Moon et al., 1998).

However, the underutilization of long-term care among immigrant elders cannot be explained by a single factor, such as greater involvement of family members in care. Other barriers to immigrant elders' long-term care utilization have also been identified, including lack of insurance, general ineligibility for regular Medicaid coverage for recent immigrants who are not U.S. citizens, lack of facilities catering to the particular cultural, religious, and linguistic needs of the immigrant elders, lack of knowledge about formal services, a fragmented long-term care system, the dearth of long-term care facilities in immigrant communities, and the cultural insensitivity of service providers (Aeschleman, 2000; Johnstone & Kanitsaki, 2008; National Institutes of Health, 2000).

Although little is known about attitudes and preferences for long-term care services for Korean American elders, one study reported that preference for long-term care among Korean American elders is in its early stage of exploration (Min, 2005). Based on data from two disability scenarios of hip fracture and stroke from a cross-section survey of 144 Korean American elders, the percentage of the respondents who showed their preference for "all formal" care arrangement was 16% in the hip fracture scenario and 51% in the stroke scenario (Min, 2005). This study also found a longer stay in the United States significantly increased the probability of a Korean American elder using formal care. Moreover, this study found traditional values affect the way some Korean American elders may respond to their long-term care needs. In other words, Korean American elders with strong adherence to traditional values might be reluctant to use appropriate formal services even if they are available, which may result in heavy reliance on family members and informal sources for care. However, such reluctance toward exploring an option of formal service care may eventually put Korean American

elders and their families in a difficult situation, by creating additional burdens and stress on the family members (Min, 2005). This reluctance may also negatively influence the effectiveness of any services or interventions provided to deal with their long-term care needs (Min, 2005).

Despite the increasing number of alternative long-term care options, including adult family homes, assisted living, or home care services, nursing homes are considered the best long-term choice for those who are frail and can no longer take care of themselves or receive care on their own (Lee, 2010). Like other immigrant elders, Korean American elders prefer to stay in their own homes as long as possible until they become frail and disabled, which may require them to receive institutional care (Lee, 2010). Mui and Shibusawa (2008) reported that 58% of Korean Americans believed that family should not let government care for elders under any circumstances (Mui & Shibusawa, 2008). However, several studies addressed the difficult situations of Korean American families taking care of their frail elders, the great burden on family caregivers, and the reluctance of Korean American elders to become a burden on their adult children (Choi, 1999; Jang et al., 2008; Kim, 1997; Min, 1997; Youn, Knight, Jeong, & Benton, 1999). These study findings imply that care for frail Korean American elders is not a family matter only; therefore, nursing homes should be considered an important resource for frail Korean American elders.

A few studies explored preferences for nursing home care among Korean American elders (Jang et al., 2008; Moon et al., 1998; Yu et al., 1993). One study found that 31% of Korean American elders felt that a nursing home is the best living arrangement when they experience rapid deterioration in their physical health status (Yu,

et al., 1993). Another study of the awareness and utilization of community long-term care services by elderly Korean and non-Hispanic White Americans found that Korean American elders utilized long-term care services when they were aware of the services (Moon et al., 1998).

Jang and her colleagues (2008) examined Korean American elders' willingness to use a nursing home and its associated factors. This study, using data from a cross-sectional study of 427 Korean American elders, found that a considerable portion of the sample (44.7%) reported that they were willing to use a nursing home. This number is far greater than that reported in a national survey of elders residing in Korea (18.9%) (Kim & Kim, 2004). This study also showed that poorer self-perceived health and having someone close living in a nursing home were identified as significant determinants of the willingness to use a nursing home. The finding is consistent with other studies showing that prior knowledge and familiarity serve as an important enabler for nursing home service use (Jang et al., 2007; Moon et al., 1998). However, this study found no significant effect from predisposing factors, including age, gender, education, and length of stay in the United States. Jang and her colleagues (2008) found that there were no ethnically and culturally oriented nursing homes within their study area and 89.4% of Korean American elders in their study sample highlighted the need for culturally appropriate and accessible nursing homes. They also found that this is a potential obstacle to nursing home use by Korean American elders regardless of their actual willingness to consider nursing home placement (Jang et al., 2008).

Nursing Home Placement and Adjustment among Korean American Elders

Views of Nursing Home Placement

Admission to a nursing home is often an emotionally difficult time for Korean-American elders, not only because they are unfamiliar with nursing homes, but also because of their negative image of a nursing home (Park & Kang, 2007). Most of the Korean American elders are neither aware of nor have utilized long-term care services available to them in the community because Korean Americans have a culture rooted in filial piety wherein care provided for the elderly by family has been accepted as a normative duty (Kim, 1991; Kim & Kim, 2001; Kim et al., 1991; Y. M. Lee, 2007; Park, & Chelsa, 2007; Park & Kang, 2007). In addition, for Korean Americans, the concept of a nursing home is different in that they regard it as a "homeless shelter for the elderly." In other words, they have a tendency to view a nursing home as a place for the elderly person who has no children or has been abandoned by his or her children (Park & Kang, 2007). Therefore, for Korean Americans, institutionalization of the elderly has been viewed as conflicting with their traditional values. Most of all, it involves many emotional issues for Korean-American nursing home residents who have high expectations of filial responsibility and family solidarity (Kim, 1991; Kim & Kim, 2001; Kim et al., 1991; Y. M. Lee, 2007; Pang, 1996).

Korean American nursing home residents rely heavily on their children for their later life care in the community (Park & Kang, 2007). Traditionally, family members, especially the first son and daughter-in-law, are the major supporters of the ill and non-ill elderly. It is considered culturally desirable for frail parents to live with a married son

(Kim, 1991; Y. M. Lee, 2007; Mui, 1996, 2001; Sung, 1995). In other words, the obligation of filial piety in caring for frail parents is still felt strongly, and it has always been assumed that filial piety plays an important role in motivating family members to care for the elderly (Kim, 1991; Y. M. Lee, 2007; Sung, 1995). Among Korean American elders, nursing home placement is an extremely stressful and shameful transition. Likewise, their children, who may have strong feelings of filial piety, feel guilty for placing their parents in a nursing home (Park & Kang, 2007).

Like other ethnic groups, for Korean American elders, ethical issues may arise in the process of admission to a nursing home due to the issue of autonomy in admission decisions. Autonomy refers to the right of an individual to make a decision in matters pertaining to his or her own life (Idziak, 2000). In Asian culture, decisions are expected to be made in a collective manner among family members (Fan, 1997). Collective decision-making is valued in Korean culture (Blackhall, Frank, Murphy, Michel, Palmer, & Azen, 1999; Kwak & Salmon, 2007). In other words, family-based decision making, particularly by children, is preferred as Korean American elders feel that their children would make better decisions on their behalf than they themselves might make (Blackhall et al., 1999; Kwak & Salmon, 2007). However, a problem for Korean American nursing home residents lies in the fact that the children often make the placement decision without consulting or involving their parents in any way (Park & Kang, 2007). Although it is preferred that placement in a nursing home be a group decision, involving the elderly person and/or "his or her family," the Korean American elders' autonomy about the placement decision is sometimes disregarded by their relatives. For Korean Americans, decisions about placement in a nursing home may be made unilaterally by the family

members, not decided mutually by the resident and his or her family members (Park & Kang, 2007). Therefore, caregivers have the responsibility of discussing alternatives with capable elderly persons in order to identify which alternative is in the elderly person's best interest medically and realistically feasible in terms of family and community supports.

Communications/Languages in Nursing Homes

Several studies indicated that ability to communicate in English is one of the most important components of a successful adjustment to a new country (Casado & Leung, 2001; Cheung, 1989; Kuo & Tsai, cited in Lam et al., 1997; Lee et al., 2004; Mui & Kang, 2006; Mui et al., 2006) and to a nursing home. At the same time, these studies pointed out that lack of English language proficiency is one of the most significant barriers to adjustment, especially among Asian American immigrants. Although English classes from the community may be a valuable resource in helping new immigrants' adjustment to this country, learning a new language may be a serious challenge for older immigrants (Casado & Leung, 2001). In addition, Casado and Leung's study (2001) showed that for older immigrants the process of learning a new language may cause psychological distress and even may result in negative reactions, such as feelings of failure and low self-esteem.

According to Kim (1997), most Korean elderly immigrants can speak only Korean. For Korean American immigrants in the Unites States, the acquisition of English language skills is ranked as the highest priority, but also as the most difficult task (Kim, 1988). Although they may learn English from classes offered in the Korean American

community, they may have very few opportunities to use and practice English in real life contexts (Min, 2000). Given these facts, it is common that first-generation immigrant communication among Korean Americans is almost exclusively in Korean and that Korean American elders rarely speak or understand English (Kim, 1997; Min, 2000).

It can be easily observed that most Korean American nursing home residents do not speak or understand English. Poor communication skills and language barriers that impede communication with other residents and staff contribute to Korean American nursing home residents' difficulties in adjustment. These may increase their levels of psychological distress and unfamiliarity with services (Lee at al., 2004; Mui et al., 2006). Furthermore, language barriers may prevent Korean American nursing home residents from effectively seeking medical and mental health services (Park & Kang, 2007). A recent study exploring the daily lives and experiences of Korean American elders living in an American nursing home indicated several disadvantages caused by language barriers, such as delayed medical treatments, lack of attention from staff, and no cultural considerations for their food, roles, or values in the nursing home (Suh & Park, 2007). In order to accommodate their needs appropriately, social workers and other staff need to use appropriate approaches to communication with them by using a staff translator, professional interpreter, or community service provider/family members.

Social Engagement and Religious Participation in Nursing Homes

Numerous studies have reported that social engagement, through interpersonal relationships and participation in social activities, enhances physical and psychological well-being and decreases mortality rates in later life (Avlund, Damsgaard, & Holstein,

1998; Everard, Lach, Fisher, & Baum, 2000; Glass, Mendes de Leon, Bassuk, & Berkman, 2006; Jang, Mortimer, Haley, & Borenstein Graves, 2004; Lennartsson & Silverstein, 2001; Thomas, 2011). For nursing home residents, those with higher levels of social activities, including religious participation, had reduced odds of dying (Kiely & Flacker, 2003; Kiely, Simon, Jones, & Morris, 2000). A study investigating the effect of social engagement on mortality in long-term care, using data from a retrospective cohort study of 927 long-term care residents indicated that residents who did not engage socially were over twice as likely to die during the follow-up period (Kiely et al., 2000).

Although there is no literature on Korean American nursing home residents' aspects and patterns of social engagement, like Korean American elders in the community, it appears that the majority of the Korean American nursing home residents have a religious identification. It is easily observed that most of the Korean American nursing home residents are affiliated with Protestantism, Buddhism, or Catholicism and exercise/practice their religious faith at the facility (Park & Kang, 2007). For instance, the most prevalent religious practices among Korean American nursing home residents are Protestantism and Catholicism. For them, religion and its practice may play a significant role in influencing physical and mental health. In addition, some of the Korean American nursing home residents may consider religious activity to be the primary source of social contact/network with the community, including socialization with other residents, as well as coping strategies to adjust to a nursing home environment. Park and Kang (2007) suggested that it is important to help them experience religious freedom and continue to practice their religious beliefs at the nursing home. It is also important to encourage community religious affiliations/organizations to provide religious services to Korean

American nursing home residents on a regular basis. Moreover, it is imperative for nursing home staff to reach out to community religious organizations to request that they provide services in a nursing home setting (Park & Kang, 2007).

CHAPTER III. REVIEW OF THE LITERATURE

In order to examine the relationship between social support and health-related quality among life of Korean American nursing home residents, this chapter will include four parts: 1) the concept of social support and its conceptual and operational definitions; 2) an examination of the relationships between social support and health-related quality of life indicators of nursing home residents; 3) a discussion of the primary variables (social support and health-related quality of life indicators) and an examination of covariates, which influence the dependent and independent variables in order to develop the conceptual framework for the study; and 4) an explanation of social exchange theory and the stress-coping framework as a conceptual model for this study. Based on the literature, a conceptual model, research questions, and hypotheses will be offered.

Social Support

The Concept of Social Support

Since the mid-1970's, there has been increasing interest in the concept of social support and the role of social support as it affects health and well-being. The concept of social support has been employed broadly by researchers in social work and other social sciences. Brownell & Shumaker (1984) demonstrated that there are several reasons that contribute to the popularity of the concept. First, interpersonal relations have long been considered central to the quality of an individual's life, and social support is a basic human requirement. Second, the bulk of research demonstrates the beneficial effects of

social supports. Third, the recognition of the importance of social ties has been applied specifically to the domains of health and emotional well-being.

However, the social support literature reflects both measurement and definitional problems, which can lead to misunderstandings and inaccurate measurement and generalizations. The lack of a commonly accepted notion of what social support means makes it difficult to integrate the results obtained from different fields because they differ in their agendas and their methods. Bruhn and Philips (1984) explained the reasons for the ambiguity, diversity, and complex nature of social support as follows: 1) social support cannot be adequately defined and measured by using a generic instrument for culture; 2) the physical and psychosocial characteristics of an individual can affect perceptions of need and of the availability of social support; and 3) existing studies have mainly focused on the positive aspects of social support without measuring any of its potential negative aspects.

As a result of the complex and multitude nature of social support, it has been described in terms of numerous concepts, definitions, dimensions, and other aspects of its nature. It is necessary, however, to clarify and identify the overall characteristics and structures of social support. Two main issues relevant to social support are discussed below: 1) conceptual definitions of social networks and social support and 2) operational definitions of social networks and social support.

Conceptual Definitions of Social Networks and Social Support

The terms “social support” and “social networks” are frequently used interchangeably but they refer to different facets of the same phenomenon. The social

support literature evinced a confusion or blurring of the distinction between social networks and social support (Schilling, 1987), and this has resulted in a lack of consensus on their definitions. It is difficult to integrate a body of literature from diverse disciplines that includes multiple perspectives, definitions, and outcomes.

The concept of social networks as applied to human groups appeared in the early writings of several sociologists and social anthropologists. Initially, the use of the network concept was largely metaphorical and did not identify specific characteristics or dimensions useful in depicting particular networks (Mitchell, 1969). Researchers' interest in a structural analysis of social network focuses on an explanation of behaviors based upon the patterned interconnections of members rather than on the independent effects of personal dispositions or dyadic relationships (Milard, 1988). Researchers of social networks have avoided explanations of behavior based on normative beliefs or categorical memberships like gender, race, or class because such explanations are inherently a structural. For example, Bott (1971) was among the first to recognize the link between the internal character of a relationship and the structure of a network by illustrating that the conjugal roles adopted by spouses depend on the connectedness of their friendship network.

From both a social and a clinical psychological perspective, the term social networks described people and their relationships with each other (Boissevain, 1977). It was used as a metaphor to describe individuals as points among their mutual ties (Laireiter & Baumann, 1992). In the social work literature, social networks are defined as the links among a set of significant others, including kin, friends, neighbors, workmates, and acquaintances (Germain & Gitterman, 1980). Schilling (1987) defined social

networks as the entirety of social links among persons in a finite community of relationships. The term is best understood as a highly differentiated and complex system of interpersonal relationships (Schilling, 1987).

A number of studies proposed that social networks refer to the structural aspects of social ties, including size, density, dispersion, homogeneity, source of ties, frequency of contacts, durability, proximity, reciprocity, and multiplexity (Berkman & Glass, 2000, Ell, 1984; House & Kahn, 1985; Vaux, 1988). It also referred to the web of social relationships that surround a person and the objective characteristics of those social ties (Ell, 1984).

The network concept covers structures, interactional features, and functions (Laireiter & Baumann, 1992). The structure of a network is categorized by various parameters, such as size, density, number of clusters, and centrality (Hall & Wellman, 1985). Interactional parameters describe the singular relationship between the "ego" and the members of its network (e.g., frequency of contact, multiplexity, reciprocity, emotional closeness, and other aspects of relationships). The functions of the networks are burden, contact, control of behavior, distress, development, and regulation. One main function of social networks is to provide social support. In short, social networks are conceptualized in terms of the structure of interpersonal relationships, and social support is conceptualized in terms of function that a relationship or network serves (Cohen & Syme, 1985).

Social support is also defined as reciprocal assistance between/among people. Shumaker and Brownell (1984) explained social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended

to enhance the well-being of the recipient" (p. 13). Vaux (1988) pointed out that this definition of social support helps focus the participants in the supportive exchange and expands the limits of social support to include more interactions than those connected to stressful or problematic situations.

On the other hand, Cohen and Syme (1985) defined social support as the resources provided to recipients by other persons. A number of factors, such as support sources, support targets, support types, and support duration, may be critical for a successful intervention. They stated that the resources provided by others can have either a positive or a negative effect (Cohen & Syme, 1985). Therefore, the issue of who provides support is critical since the same resource may be accepted from one giver but rejected from another (Cohen & Syme, 1985).

Schilling (1987) defined social support as the comfort, assistance, and/or information one receives through formal or informal contacts with individuals or groups. Caplan (1974) suggested that social support systems consist of continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations of others. House (1981) demonstrated that social support is an interpersonal transaction involving one or more of the following: 1) emotional concerns – liking, love, empathy; 2) instrumental aid – goods and services; 3) information; and 4) appraisal – information relevant to self-evaluation. Cobb (1976) also defined social support as information belonging to one or more of the following three classes: 1) information leading the subject to believe that he/she is cared for and loved; 2) information leading the subject to believe that he/she is esteemed and valued; and 3) information leading the subject to believe that he/she belongs to a network of

communication and mutual obligation (p. 300). In other words, social support is taken as an indication that one is loved and wanted, valued and esteemed, and able to count on others should the need arise. In sum, social support is used to describe the more subjective traits of social ties, focusing on the quality and nature of interactions among members of a social network (Lubben & Gironda, 2003).

While there is no one definition of the terms social network and social support, Berkman (1984) pointed out that social network and social support are distinctive concepts. Social network is the web of social ties that surround an individual, while social support, on the other hand, is the instrumental, emotional, and financial aid that is offered by one's social network.

Operational Definitions of Social Networks and Social Support

As described above, social networks are conceptualized in terms of the *structure* of relationships and social support is conceptualized as the *function* of relationships. Measuring the structures of social networks entails investigating the existence of and interconnections among social ties, for example, their size, density, content, accessibility, directedness or reciprocity, durability, intensity or emotional closeness, frequency of contact, dispersion, and homogeneity (Hall & Wellman, 1985; House, Robbins, & Metzner, 1982). Measuring the function of social support involves finding whether interpersonal relationships serve particular functions, such as providing affection, a feeling of belonging, or material aid. Structural measures are generally considered to measure the existence of and interconnections between/among social ties, such as marital status, number of relationships, or number of individuals who know one another, while

functional measures generally ask persons about their perceptions of the availability or adequacy of resources provided by other persons (Cohen, 1988; Cohen & Syme, 1985).

Social support is defined operationally as the provision of assistance to a member of a social network by one or more members of that social network. It is often differentiated among four types of resources: emotional, instrumental, informational, and appraisal aid (House, 1981; House & Kahn, 1985; Krause, 1986). *Emotional support* contains empathy, acceptance, affection, sympathy, concern, esteem, trust, and listening to the recipient (House, 1981; Krause, 1986). It provides opportunities for emotional expression and release of strong feelings. *Instrumental support* involves the provision of tangible goods and services, or tangible aid (Barrera, 1986; House, 1981; Krause, 1986). It provides goods and services, financial assistance, labor, time, and modifications to a recipient's environment. *Informational support* refers to the provision of relevant information intended to help the individual during a time of stress (House, 1981; Krause, 1986). It includes advice, suggestions, directives, and information and provides a solution to a problem. *Appraisal support* refers to the communication of information relevant to self-evaluation, rather than problem-solving (House, 1981). It includes affirmation, assurance, feedback, and social comparison.

The operational definition of social support contains several important factors. First, it demands the identification of the boundaries of the social network and the members contained within it. The identification of network boundaries substantiates the social connectedness and clarifies the social relationships among the members. Second, it allows for a non-reciprocal response by the receiving party. Third, the definition does not

judge the utility of the social support proffered; the assistance may be helpful, unhelpful or neutral. Thus a wider spectrum of supportive behaviors can be included for this study.

Health-related quality of life indicators are operationalized for this study as Activities of Daily Living (ADL) impairments, depressive symptoms, and self-rated health.

Social Support and Health Indicators

The health of the nursing home resident is a complex interaction of medical diagnoses, physical and functional capacities, clinical symptoms, and subjective experience. It may be operationalized through objective clinical measures, subjective reporting, and program outcomes. *Clinical measures* include medical diagnoses, physical symptoms, activities of daily living (ADLs), incidence and frequency of falls, continence, cognitive status, mood symptoms, and physical restraints. *Subjective reporting* contains reports regarding pain and rankings of personal health. *Program outcomes* consist of length of stay (LOS), discharge status, and mortality risk. The present study will focus on three health indicators that reflect the Korean American nursing home resident's quality of life: ADL functioning, depressive symptoms, and self-rated health. Other health indicators will be examined as covariates.

Social Support and ADL Functioning

The term ADL encompasses the range of tasks necessary for the basic self-care of the individual: ambulating, eating, bathing, toileting, dressing, grooming, and transfers, and so on (Drageset, 2004; Wiener, Hanley, Clark, & Van Nostrand, 1990). With

advancing age, many older adults are vulnerable to a decline in physical functioning (Fiksenbaum, Greenglass, Marques, & Eaton, 2005; Greenglass, Fiksenbaum, & Eaton, 2006). According to previous research, demographic factors are related to functional impairment, such as being female (Murtagh & Hubert, 2004; Wray & Blaum, 2001) and chronic diseases including arthritis, diabetes, and hypertension (Boult, Kane, Louis, & McCaffrey, 1994). Among chronic conditions, osteoarthritis is the leading cause of long-term disability in the United States (Katz, 2001). Other study findings indicated that the resulting pain and disability can limit mobility and decrease functional independence (Reid, Williams, & Gil, 2005; Rissanen, Aro, & Sintonen, 1996). Acute cardiovascular events, impaired cognition, and fear of falling have also been negatively associated with physical function (Cumming, Salkeld, Thomas, & Szonyi, 2000; Rolland, Pillard, Klapouszczak, Reynish, Thomas, Andrieu, Riviere, & Vellas, 2007; van Wijk, Algra, van de Port, Bevaart, & Lindeman, 2006). As functional levels are not static, individuals may become more dependent in ADL's. Therefore, elders with multiple physical impairments are often placed in nursing homes (Drageset, 2004).

Residents in nursing homes may experience diminished functions of ADLs. Studies indicated that more than a third of all residents receive extensive assistance with four of five activities of daily living (CMS, 2001), including bathing 93.8%, dressing 86.5%, toileting 56%, eating 47%, and transfers 29% (Jones, 2002).

Empirical evidence shows a relationship between social support and health status, mortality, and risk of entry into institutional care (Bowling, 1994). Studies indicated that high functional impairment among the elderly is associated with higher rates of institutionalization (Fiksenbaum et al., 2005; Johnson & Wolinsky, 1999; Worobey &

Angel, 1990). Another study reported that physical immobility, incontinence, and psychiatric problems are the strongest predictors of institutionalization (Morris, Sherwood, & Gutkin, 1988). High levels of ADL impairment were associated with a lower probability of being discharged to the community (Greene & Ondrich, 1990; Murtaugh, 1994). Others reported that lack of social support is the strongest predictor of institutionalization (Brock & O'Sullivan, 1985; Steinbach, 1992).

In terms of the relationship between social support and physical health status, low levels of social support were related to a number of negative physical health outcomes, such as higher mortality risks (Berkman, 1995; Giles, Metcalf, Glonek, Luszcz, & Andrews, 2004; Newsom, & Schulz, 1996; Tucker, Schwartz, Clark, & Friedman, 1999). For example, older adults with limited social support were 3.6 times more likely to die within the next five years than those with extensive support (Blazer, 2006). Newsom and Schulz' study (1996) examined the relationship between functional disability, social support, depressive symptoms, and life satisfaction using 4,734 adults aged 65 years and older. According to their study findings, fewer contacts with family and friends and less social support were related to an increase in functional disability and depressive symptoms. One study indicated that greater social support is associated with lower levels of cardiovascular activation in response to stressful life events and concomitant reductions in the risks of health problems, such as heart disease and hypertension. (Seeman & Crimmins, 2001).

Among dimensions of social support, frequency of visitation has a significant positive relationship with ADL impairment. The study findings indicated that residents who were more impaired with ADLs tended to be visited more frequently than those who

were less impaired (Greene & Monahan, 1982). They theorized that highly impaired residents may have been cared for previously in the community by highly motivated caregivers, who continued to maintain their pre-institutional level of involvement. In addition, residents who were less impaired may be in the nursing home due to a lack of community caregivers who are actively involved with care (Greene & Monahan, 1982).

Social Support and Depressive Symptoms

Depression is a common psychiatric disorder in later life. Previous studies have consistently indicated that depression increases mortality and has a negative impact on the well-being and daily functioning of elders (Anstey, von Sanden, Sargent-Cox, & Luszcz, 2007; Chuan, Kumar, Matthew, Hoek, & Pin, 2008; Parmelee, Katz, & Lawton, 1992). In particular, nursing home residents are at increased risk for depression due to physical and cognitive disability, separation from familiar environments, potential loss of social support from family and friends, loss of control over daily activities, and reduced opportunities for social activities (Konnert, Dobson, & Stelmach, 2009). Among nursing home residents, prevalence rates have been found ranging from 6% to 26% for major depression, from 11% to 50% for minor depression, and from 30% to 48% for depressive symptoms (Smalbrugge, Jongenelis, Pot, Beekman, & Eefsting, 2008). Other studies indicated that estimates of the prevalence of clinical depression among elderly nursing home residents range from 9% to 30% (Payne et al, 2002; Rovner et al., 1991), with high levels of depressive symptoms in over two-thirds of nursing home residents (McCurren, Dowe, Rattle, & Looney, 1999). One study found that more than 60% of cognitively

intact residents in a nursing home had depression (Rinaldi, Mecocci, and Benedetti, 2003).

The treatment of depression in nursing homes is largely pharmacological (Konnert et al., 2009). One study using data from Ohio's Minimum Data Set for 76,735 residents in 921 nursing homes found that, among residents diagnosed with depression, 23% received no treatment, 74% received anti-depressants, 0.5% received psychotherapy and 2% received both interventions (Levin, Wei, Akincigil, Lucas, Bilder, & Crystal, 2007). Although depression is a prevalent condition in nursing homes, depression is underdiagnosed, underreported, and undertreated (Meeks, Young, & Looney, 2007; Rovner et al., 1991).

Several studies found that greater satisfaction with social support is associated with lower levels of emotional distress (Antonucci, Fuhrer, & Dartigues, 1997; Antonucci & Jackson, 1987; Jang, Haley, Mortimer, & Small, 2002; Segal, 2005). In these studies, social support is identified as an individual's primary coping resource, which provides him or her with security, self-worth in times of crisis, and a sense of identity (Antonucci, et al., 1997; Antonucci & Jackson, 1987; Jang et al., 2002). Although studies have found a positive association between social support and depression (Antonucci, et al., 1997; Antonucci & Jackson, 1987; Jang et al., 2002; Segal, 2005), inconsistent findings have been shown in other studies (George, 1992).

Social support is an important factor in mental health among nursing home residents (Segal, 2005). His study assessing the relationships of assertiveness, depression, and social support by using 50 older nursing home residents found that there was a correlation between social support and depression (Segal, 2005). Nelson (1989) also

found that social support is inversely correlated with depression. According to the author's findings, several features of the social network-size, frequency of contact, duration, and task-were significantly and negatively correlated with depression. In addition, affection, affirmation, and aid showed significant inverse relationships to depression (Nelson, 1989). Another study examined the relationship of perceived social support and depression among 83 nursing home residents and found that source of support was also associated with depression (Commerford & Reznikoff, 1996). Their findings indicated that perceived support from family was negatively related to depression but perceived social support from friends was not significantly related to depression (Commerford & Reznikoff, 1996). Another study using 70 nursing home residents reported that the quality of relationship, as measured by perceived satisfaction, was negatively associated with depression even when controlling for health status and source of support (Farber, Brod, & Feinbloom, 1991). However, they did not find a significant correlation between frequency of contact/interaction and depression.

Greene and Monahan (1982) examined the causal modeling of frequency of visitation and psychosocial impairment. Psychosocial impairment was operationalized as agitation, confusion, depression, regression, and verbal and physical hostility. According to their findings, frequency of visitation was significantly and negatively related with psychosocial impairment. They also found that the degree of psychosocial impairment was not a significant predictor of visitation, suggesting that the negative correlation between frequency of visitation and psychosocial impairment reflected the therapeutic impact of visitation on the problem behaviors (Greene & Monahan, 1982).

In sum, research suggests that social support has a positive effect on depression among nursing home residents. The source of support appears to be relevant in that family members appear to reduce depressive symptoms more than friends. With respect to nursing home residents' depressive symptoms, qualitative support (satisfaction with the level of support) appears to be a better predictor of positive outcome than quantitative support. In addition, frequency of contact/visitation exhibits a negative correlation with depression and has a therapeutic influence on problem behaviors among nursing home residents

Social Support and Self-rated Health

Self-rated health is the individual's perception, or subjective rating, of his or her own health status (Idler & Ksal, 1991). Assessing self-rated health involves both the subjective assumptions/evaluations and actual information and knowledge of one's own health status (Idler & Benyamini, 1997; Kapan & Baron-Epel, 2003; Pinquart, 2001). Self-rated health is considered a legitimate indicator of overall health status, providing a valid, reliable, and cost-effective means of health assessment (Kapan & Baron-Epel, 2003). A resident's health judgment seems to be based on biomedical, functional, and emotional components (Kaplan & Baron-Epel, 2003). As a subjective aspect/rating, it can illuminate the quality of life experience of the individual. Self-rated health may be contrasted with "objective" aspects/ratings of health, which are usually performed by a physician or other health professionals and include direct observation and/or medical tests and procedures. There has been a debate related to the validity of objective ratings when compared to self-ratings (Clark, 1995; Idler & Kasl, 1991).

Researchers have found that self-rated health is a predictor of mortality in older adults (Benyamini & Idler, 1999; Bond, Dickson, Matthews, Jagger, & Brayne, 2006; Deeg & Bath, 2003; Deeg & Kriegsman, 2003; Idler, 2003; Idler & Benyamini, 1997; Idler & Kasl, 1991; Saevareid, Thygesen, Nygaard, & Lindstrom, 2007; Wolinsky & Johnson, 1992), even after controlling for health problems, physical disability, and biological or lifestyle risk factors (Idler & Kasl, 1991). In addition, several studies indicated that self-rated health is a good predictor of future health status as measured by mortality, decline of functional abilities, and nursing home placement (Atchley & Scala, 1998; Bond et al., 2006; Saevareid et al., 2007).

There is variability among nursing home residents regarding their perceived health. Among nursing home populations, favorable self-rated health has been statistically correlated with life satisfaction (Harel & Noelker, 1982; Saevareid et al., 2007).

The role of social support and self-rated health has not been explored among the institutionalized elderly but it has been examined in community elderly samples. Studies found that satisfaction with support had a positive influence on self-rated health (Antonucci, 1990; Harel & Noelker, 1982; Krause, 1987). Krause's study findings pointed out that older adults dissatisfied with the amount of social support they had received were more likely to rate their health as poorer than elderly adults satisfied with the support they had received (Krause, 1987). His study suggested that satisfaction with support was an important determinant of self-rated health and that this relationship remained significant after controlling for the effects of the amount of support that was provided (Krause, 1987). Moreover, it is important keep in mind that because declining

health tends to draw more instrumental support from the network, instrumental support is typically negatively related to self-rated health, whereas the reverse is true for emotional support (Deeg & Kriegsman, 2003; Liu, Liang, & Gu, 1995). Krause (1987) further pointed out that the type of support provided was important: satisfaction with tangible and emotional support had a positive influence on self-rated health whereas satisfaction with informational support and social integration had no effect. Frequency of support was not statistically associated with self-rated health.

Covariates

This section will examine factors that influence the health status of the nursing home resident. The factors include perceptions of control, the residents' demographic characteristics, program outcomes, medical factors, recreational/social activities, and nursing home characteristics.

Perceived Control

Perceived control is a conceptually complex variable, spanning the concepts of personal autonomy, authenticity, independence, advanced directives and informed consent (Kane, 1991). In this study, perceived control refers to the subjective experience of a resident's ability to manipulate the environment. In other words, it refers to the degree to which individuals perceive having personal power and mastery over their life and environment (Schieman, 2001; Zarit, Pearlin, & Schaie, 2003). A body of literature demonstrated the connections of higher perceived control with greater physical and

emotional well-being (Anderson & Puggaard, 2008; Cohen-Mansfield, 1990; Cohen-Mansfield, Werner, Weinfield, Braun, Kraft, Gerber, & Willens, 1995; Jang, Kim, & Chiriboga, 2006a, 2006b; Lachman & Weaver, 1998; Schieman, 2001). Several studies reported the significant role of perceived control for the physical and mental well-being of nursing home residents (Anderson & Puggaard, 2008; Cohen-Mansfield et al., 1995). The association between perceived control and health is intriguing in a nursing home setting. Perceived control has positive effects on functional health and morale in the first month following nursing home admission, but has negative effects between the second and fourth months (Davidson & O'Connor, 1990). The findings of a study by Janoff-Bulman and Marshall (1982) suggested a similar association: residents with lower perceived control were most likely to have a lower morale but were more likely to be alive at the two and one half year follow-up. The findings suggested that perceived control may be adaptive in the short term but may be lost as the stay lengthens and, therefore, may be maladaptive for a long-term stay.

In sum, the process of institutionalization appears to reduce the perceived control of the residents. The decline in perceived control may be an adaptive response to the institutional setting, as higher perceived control is associated with lower functional status.

Age

Nursing home residents are predominantly elderly with a median age of 82. Residents are predominantly female and they tend to be older than males (CMS, 2001; Dey, 1997). Network size has been correlated negatively with age, with reductions occurring in the outer circles of social networks (Lang & Carstensen, 1994). Another

study found that older residents were more likely than younger residents to expand their network size (Kahana, Kahana, & Young, 1985). The findings indicated that elders are able to maintain emotionally close relationships despite social losses and that advanced age does not limit opportunities for closeness.

Gender

Gender differences in network size have not been found in nursing home samples (Kahana et al., 1985) although they have been reported among community elderly, with women having slightly larger networks and more different types of relationships (Bowling, 1991; CMS, 2001; Cohen & Dubay, 1990; Greene & Ondrich, 1990; Miller & Weissert, 2000). Females were more likely than males to report a close relationship inside the nursing home (Bitzan & Kruzich, 1990). Gender differences in frequency of social contacts have not been found significant, although female residents appeared less socially isolated than males (Kahana et al., 1985; Commerford & Reznikoff, 1996). Women were more likely than men to perceive higher levels of support from family members (Antonucci, 1990; Commerford & Reznikoff, 1996). Antonucci (1990) demonstrated that women tend to have more people in their social networks and to receive support from multiple sources. Studies found that gender does not appear to be associated with perceived control (Arling, Harkins, & Capitman, 1986; Kane, Caplan, Urv-Wong, Freeman, Aroskar, & Finch, 1997).

Marital Status

Two thirds (66%) of nursing home residents were widowed; only 16.5% were married (CMS, 2001; Dey, 1997). Married nursing home residents appeared more socially engaged in terms of visitation and communication patterns than any other marital status. They were more likely to retain the same confidence before and after hospitalization. Marital status has not been correlated with perceived control (Arling et al., 1986).

The social networks of the elderly play a mediating role in admission and discharge to the nursing home. The presence of family can postpone or prevent nursing home admission, reduce length of stay, and increase discharge to the community. Higher rates of nursing home placement are reported among the unmarried or never married elderly (Greene & Ondrich, 1990; Kemper & Murtaugh, 1991; Steinbach, 1992). Caregiving appeared to reduce the risk of institutionalization (Buhr, Kuchibhatla, & Clipp, 2006), while caregiver burden increased the risk of placement (Buhr et al., 2006; Collins & Kokinakis, 1993; McFall & Miller, 1992).

Socioeconomic Status and Education

Nursing home population studies utilize proxy variables to measure SES because much of this population is retired from the labor force and receiving a fixed income and/or in-kind benefits. An accurate measure of the residents' SES is elusive. SES and education have not been studied in relation to social support among nursing home resident but will be included as part of the demographic profile.

Source of Payment

Source of payment refers to the method by which the resident pays for room, board, and nursing care. It includes the various entitlement programs of Medicare, Medicaid, the Veteran's Administration, and private pay. According to the 1995 National Nursing Home Survey, the source of payment for current residents was: 32% private pay; 38% Medicaid; 25% Medicare; and 4% all other resources (Dey, 1997). Source of payment has not been studied in relation to social support in nursing home samples.

Medical Diagnosis

According to the 1995 National Nursing Home Survey, the most frequent primary diagnoses were diseases of the circulatory system, mental disorders, and nervous system (Dey, 1997). The majority of the residents have two or more diagnoses, with the average number of diagnoses being 3.3 (CMS, 2001). During the course of a nursing home stay, the residents' health may improve, decline, or remain the same. New admissions tend to be more clinically fragile than the resident cohorts (CMS, 2001). Approximately 21% of new admissions die within the first three months of admission and about 36% remain in the facility for one year and more (Spence & Wiener, 1990).

Length of Stay

The average length of stay of elderly nursing home residents was 838 days (Dey, 1997). Length of stay is associated with social support. The presence of family has been associated with decreased length of stay (Buhr et al., 2006; Freedman, 1993; Spence &

Wiener, 1990). Unmarried persons have almost twice the risk of a permanent nursing home admission as those who are married (Buhr et al., 2006; Spence & Wiener, 1990).

Studies on length of stay and visitation have consistently yielded a negative correlation; residents with a longer length of stay are visited less frequently than residents with a shorter length of stay (Hook, Sobal, & Oak, 1982; Parmelee, 1982). Persons with a length of stay greater than five years reported lower perceived social support than persons with shorter stay (Commerford & Reznikoff, 1996). Perceived social support from family and friends were highest for those with lengths of stay between 2 and 5 years (Commerford & Reznikoff, 1996).

Discharge Status

The association between social support and discharge status is inconclusive. Studies reported that married persons were 66% more likely to be discharged to the community (Murtaugh, 1994; Weissert & Scanlon, 1985). Others have not found an association between marital status, living arrangement, and discharge home (Greene & Ondrich, 1990). In terms of the association between frequency of visitation and discharge outcome, frequency of visitation during the initial admission month was significantly associated with immediate discharge status (Lewis, Kane, Cretin, & Clark, 1995).

Recreational/Social Activities

Nursing homes, by law, must provide opportunities for structured and unstructured activities. Participation in recreational/social activities provides social interactions with others, fulfilling a basic human need for affiliation, and building a sense

of community (Maier & Klumb, 2005). Greater participation in social activities has been correlated positively with higher morale, higher life satisfaction, positive health outcomes, increased self-efficacy, sense of belonging, reduced depressive symptoms, and even lowered mortality (Buchman, Boyle, Wilson, Fleischman, Leurgans, & Bennett, 2009; Glass et al., 2006; Hong, Hasche, & Bowland, 2009; Isaac, Stewart, Artero, Ancelin, & Ritchie, 2009; Kiely & Flacker, 2003; Kiely et al., 2000; Lawton & Parmelee, 1995; Meeks et al., 2007; Morrow-Howell, Hinterlong, Rozario, & Tang, 2003; Perkins, Multhaup, Perkins, & Barton, 2008; Spector & Takada, 1991). By contrast, reduced activity time has been associated with increased one-year mortality (Flacker & Kiely, 1998).

Nursing Home Characteristics

Nursing homes are analyzed according to structural and functional features, including acuity level, certification level, organizational structure, ownership type, size, source of funding, staffing, and social climate. There features are interrelated and determine the quality of care provided by the nursing home. Quality of care is both a process and an outcome and is difficult to measure. No single indicator of quality of care has been identified by policy analysts or researchers. Nonetheless, several studies reported that attributes of the nursing home appear to impact the health outcomes of the residents, such as mortality rates, functional levels, and clinical outcomes (Aaronson, Zinn, & Rosko, 1994; Cohen & Spector, 1996; Reed & Washington, 1984; Rohrer, Momany, & Chang, 1993; Spector & Takada, 1991; Timko & Moos, 1991). Study findings indicated more positive health outcomes for non-profit homes (Davis, 1991;

Lucas, Lowe, Akincigil, & Sambamoorth, 2007; Spector & Takada, 1991. Greater percentages of Medicaid support are associated with a lower probability of discharge and a greater likelihood of functional decline. Low registered nurse turnover, increased registered nurse and licensed practice nurse hours, and greater organizational flexibility are associated with positive resident outcomes (Lucas et al., 2007).

Theoretical Framework

In this study of Korean American nursing home residents, social exchange theory and a stress-coping framework are used to conceptualize and examine the relationship between social support and health related quality of life. The conceptual frameworks for this study are interrelated.

Social Exchange Theory

The conceptual framework of social support is social exchange theory. Social exchange theory is based on the hypothesis that personal status is defined by the balance between people's contribution and the costs of social interactions (Hooyman & Kiyak, 2008). Social exchange theory is viewed as a process of central significance in social life and as underlying the relations between groups as well as between individuals (Blau, 1964). Blau (1964) emphasized primarily the reciprocal exchange of extrinsic benefits and the forms of association and emergent social structures that this kind of social interaction created. In social exchange theory, social interactions are viewed as a series of transactions. The transactions are defined as "voluntary actions of individuals that are

motivated by the returns they are expected to bring and typically do in fact bring from others" (Blau, 1964, p.91). He argued that social exchange "involves the principle that one person does another a favor, and while there is a general expectation of some future return, its exact nature is definitely not stipulated in advance" (Blau, 1986, p. 93). Social exchange is also defined as "the exchange of activity, tangible or intangible and more or less rewarding or costly, between at least two persons" (Homans, 1961, p. 13). The social returns of exchange interactions include goods, services, and sentiments (respect, approval, and affection). The costs of exchange transactions are foregoing an alternate and rewarding activity, i.e., the loss of a reward (Homans, 1961). This perspective of social exchange theory assumes that people make efforts to maximize the social returns and to minimize the costs of exchange transactions. The balance of interactions existing between generations determines personal satisfaction (Hooyman & Kiyak, 2008). Therefore, individual adjustment relies on the immediate costs and the social returns or rewards between persons (Bengtson, Burgess, & Parrott, 1997).

Applied to aging, the social exchange theory perspective explains exchange behavior between individuals of different ages as a result of the shift in skills, roles, and resources that accompany advancing age (Hendricks, 1995). This theory offers explanations of the balance of interactions between older persons and other members of society. In addition, social exchange theory seeks to understand how exchange behaviors reflect the changing circumstances of the elderly and those with whom they interact, such as family members or others (Hendricks, 1995).

A central tenet in the social exchange framework is that each individual brings resources to the interaction, and that these resources are usually unequal (Hendricks,

1995). A second tenet is that people will only continue to engage in exchanges for as long as the benefits are greater than the costs (Hendricks, 1995). Third, it is assumed that exchanges are governed by norms of reciprocity (Gouldner, 1960); Gouldner (1960) posits that a norm of reciprocity operates within this culture in that people usually return the benefits they receive from others. The process of reciprocity is a universal norm that gives stability to social systems (Gouldner, 1960).

Reciprocity is linked to the element of time in that the social exchange relation links each transaction to a history and a future (Emerson, 1972). The exchange relation assumes that there will be an ending connection that may vary in intensity with the passage of time. Reciprocity is also governed by social norms of fair exchange known as distributive justice. The social norms serve to guide and protect the participants of social exchanges.

If the exchange actors believe that the norms of reciprocity were not met, an asymmetrical balance occurs. Asymmetrical exchange creates relationships of indebtedness, dependence, and exploitation. Elderly individuals who have experienced age-related changes in income and social status may lack the personal resources needed for balanced exchanges. Elders typically have fewer opportunities and resources with which to exert power in their social relationships, and their status declines accordingly (Hendricks, 1995). According to Dowd (1975, 1980), the only exchange resources available to the elderly are compliance and dependence. He theorizes that many elderly persons disengage from social interaction and activity rather than pay the high costs of remaining engaged, i.e., dependence and social compliance. In other words, he argues

that social isolation or withdrawal result in an unequal exchange process of "investments and returns" between the elderly and other members of society.

However, Antonucci and Jackson (1990) argued that Dowd's theory is limited because it is temporally static. Based on their longitudinal perspective on social exchanges, individuals maintain a psychological "Social Support Bank" of "deposits" and "withdrawals" which accrue over a lifetime of social exchanges. Therefore, the aging individual faced with increasing needs and diminishing resources can avoid feelings of dependence or low self-esteem by recalling earlier "deposits" s/he made into the support bank and from which s/he can now withdraw. According to their view, this psychological mechanism permits the individual to maintain reciprocity throughout the life span.

There is room for both theories in the great diversity of human exchanges. A psychological mechanism for calculating obligations explains how individuals and societies "keep score" over time. Some individuals may disengage from social relations or interactions when their social "currency" is depleted. The insufficient credit may be a function of lifelong asymmetrical social relations, or a lifelong distortion in calculating reciprocal obligations.

The Stress-Coping Paradigm

The relationship between social support and health emerged from the stress-coping paradigm. Studies on the stress-coping paradigm, which describes how individual efforts to manage distressing problems and emotions affect the physical and psychological outcomes of stress, have proliferated since the late 1970s (Somerfield & McCrae, 2000).

According to the stress and coping framework, stress refers to any environmental, social, or internal demand which requires the individual to readjust his/her usual behavior patterns (Holmes & Rahe, 1976). Stress is conceptualized as conditions that are perceived by the individual as a potentially difficult situation (Aldwin, 1994; Lazarus & Folkman, 1984) or as life events that create change and require adaptation (Lazarus, 2000; Lazarus & DeLongis, 1983). This views stress as an unfolding process involving changes among related components around human experiences. Sources of stress include major life events, chronic strains, and daily hassles (Pearlin & Schooler, 1978; Pearlin, Turner, & Semple, 1989).

Stress is a subjective perception and response that affects physical health and psychological well-being (Lazarus & Folkman, 1984). In addition, stressors are linked with negative mental health outcomes such as depression and anxiety (Lazarus & Folkman, 1984). However, studies utilizing the stress process framework suggest that stress does not automatically produce negative effects in all individuals who experience it (Hadjistavropoulos, Taylor, Tuokko, & Beattie, 1994; Haley, Levine, Brown, & Bartolucci, 1987). Rather, stress arises based on an individual's response to his or her environment (Lazarus & Folkman, 1984). The experience of stress is mediated by how the situation is viewed by the person in terms of its relevance to his or her well-being and personal resources available to manage the events causing the stress (Lazarus & Folkman, 1984). In other words, responses to stress are associated with an individual's emotional ability to cope and the resources that enable him or her to do so, including physical, psychological, and social skills, as well as social support, which is seen as mitigating stress (Pearlin & Schooler, 1978).

"Coping" refers to ongoing cognitive and behavioral efforts to manage specific situational demands that are appraised as taxing or exceeding one's ability to adapt (Lazarus & DeLongis, 1983; Lazarus & Folkman, 1984). Coping may be directed at the demands themselves (problem-focused) or at the emotional reactions which often accompany those demands (emotion-focused) (Lazarus & Folkman, 1984). Problem-focused coping is directed at managing or altering the problem causing the distress. It can include various strategies, such as defining the problem, formulating alternative solutions, analyzing the cost or benefits, acting upon a solution, and practicing confronting behaviors (Lazarus & Folkman, 1984). Emotion-focused coping is directed at regulating emotional distress caused by a problem. It can include various strategies, such as wishful thinking, avoidance, interpreting events as opportunities for personal growth, and seeking social support (Lazarus & Folkman, 1984). In general, problem-focused coping is more likely when situational demands are appraised as controllable; emotional-focused coping is more likely when demands seem uncontrollable (Coyne, Aldwin, & Lazarus, 1981; Folkman, 1984; Folkman & Lazarus, 1980, 1985; Thoits, 1995). In addition, coping may be described as adaptive or maladaptive, successful or unsuccessful. Pearlin and colleagues (1989) suggested the four coping functions as 1) prevention of the stressful situation, 2) management of the situation including termination of the situation, 3) management of the meaning of the situation, and 4) management of stress symptoms.

Studies demonstrated that social support is a coping resource that the individual utilizes for managing stress (Lazarus & Folkman, 1984; Thoits, 1986, 1995). Cobb (1976) examined the role of social support in human adaptation and demonstrated that social support was instrumental in enhancing the individual's coping and adaptation to

life events such as pregnancy, birth, hospitalization, illness, bereavement, aging, retirement, and the threat of death.

Predictable life events for older adults include retirement; loss of spouse, family, or close friends; the decline of physical, social, and financial status; institutionalization; and death (Aldwin, 1990; Minkler, 1985; Shibusawa & Mui, 2001). Several studies demonstrated predictable life events and sources of stressors for older minority groups (Cheung, 1989; Damron-Rodriguez et al., 1995; Kao & Lam, 1997; Y. M. Lee, 2007, Mui & Kang, 2006; Mui et al., 2007; Tsai & Lopez, 1997). These include fear of racial discrimination; lack of culturally appropriate services; loss of familiar environment, support systems, identity and status; language barriers; altered social resources; and changes in family relationships.

For the nursing home resident, potentially stressful events include acute or chronic illness, relocation within a nursing home, financial burden, adjustment to institutional living, the death of family and close friends, and job transfers of favorite staff. These life events have the potential to alter both the structure and the function of the social network (Kaplan & Toshima, 1990). Social losses may reduce the size of the social network and the availability of support (Kaplan & Toshima, 1990).

The role of social support as a coping resource parallels social exchange theory. As social resources, network members represent a social "fund" from which people may draw social support "capital." The fund may be increased or diminished by expanding or reducing the size of the social network. The available capital may be invested in or depleted through social support transactions (Tijhuis, Flap, Foets, & Groenewegen, 1995; Thoits, 1995).

The mechanism by which social support effectuates coping continues to be a source of debate. There exist two schools of thought: the main (direct)-effects school and the stress-buffering theory (Cohen & Mckay, 1984; Cohen & Wills, 1985). The main-effects school proposes that a perception of a high degree of social support contributes to well-being of individuals (Robinson & Garber, 1995). According to the main-effects school, social support enhances health and well-being regardless of stress level. In other words, the main-effects school shows that social support is beneficial to all recipients no matter what the levels of stress are (Cohen & Wills, 1985). One study found that the direct effects of social support have consistently occurred regardless of the severity of stress while the buffering effects have occurred inconsistently (Hashimoto, Kurita, Haratani, Fujii, & Ishibashi, 1999). When an individual perceives adequate social support, he/she may feel protected from distress or stressful events (Lang, Featherman, & Nesselroade, 1997). The main (direct)-effects school also shows that individuals are better protected in coping with stressful events by their support relationships prior to the occurrence of such stressful events. One study found that adequate social support has positive effects for an individual regardless of the severity of one's life circumstances (Williams, Ware, & Donald, 1981). Moreover, the main (direct)-effects of social support enhance health and well-being in stressful life events (Cohen & Wills, 1985; Dunst, 1985; Trute, 1995). Cohen and Wills (1985) found consistent evidence for the beneficial main (direct)-effects of social support on well-being in studies using measures of social embeddedness and enacted support.

Stress-buffering theory proposes that social relationships may protect individuals from harmful impacts of life stress by minimizing the likelihood of an undesirable

experience (Cohen & Syme, 1985; Cohen & Wills, 1985). Stress-buffering theory posits that social support protects an individual from the potential harm of stressful events (Cohen & Wills, 1985). According to Cohen and Wills (1985), stress-buffering theory is effective when available social support is properly responsive to the needs elicited by stressful events. Stress-buffering theory authors illustrate how social support serves to alleviate stress once the individual perceives a stressful situation. According to stress-buffering theory, social support exerts a beneficial effect by moderating the deleterious effects of existing stressors (Cohen & Syme, 1985). In other words, the stress-buffering hypothesis posits that social support cushions the individual against the negative health impact of stressful life events. However, stress-buffering theory has been criticized for conceptual, operational, and methodological problems. One study pointed out that life events themselves may produce changes in the social support system, thus confounding the buffering effect (Thoits, 1982).

Studies from the two schools have yielded mixed findings. Some studies showed that social support exerts both a direct and a buffering effect (Cohen, Teresi, & Holmes, 1985; Revicki & Mitchell, 1990). The findings indicated that social support exerts a direct effect on reducing symptoms and enhancing ability to meet needs. In addition, the findings pointed out that social support triggers a buffering effect on stressors in that their ability to reduce symptoms and to enhance need fulfillment was greatest among high-stress individuals. Other studies found that social support mediated the impact of stressors, “measured as functional impairment”, upon symptoms of distress and depressive symptoms (Arling, 1987; Greenglass et al., 2006; Lin, Ye, & Ensel, 1999). By contrast, several studies found no evidence of systemic buffer effects between life events

and the occurrence of illness (Tijhuis et al., 1995), or of social support between daily hassles and depressive symptoms (Russell & Cutrona, 1991). Another study (Roberts, Dunkle, & Haug, 1994) also found that social support did not attenuate the impact of strain upon mental health. It would appear that both schools have theoretical validity but empirically the results have been inconsistent.

In sum, both schools are similar in describing the effect of social support but different in explaining the process of that effect on distress and stressful events: the relationships between perception of social support and enactment of social support. Although the differences between the two schools consist in their effectiveness on stressful events, individuals with high levels of social support would have more chances to escape from or alleviate stressful situations. In addition, it is reasonable to consider that social support has an impact on health and well-being of the individuals through both the main (direct)-effects and stress-buffering effects. The reason is that the stress-buffering effects may occur prior to an anticipated stressful event or after the stressful event but before the onset of a stressful result. Therefore, it is useful to understand how social support can be used to adjust to a major change, such as a nursing home placement, through the lens of both the main (direct)-effects and stress-buffering effects.

Conceptual Framework, Research Questions, and Hypotheses

Conceptual Framework of the Study

Although there is no empirical literature focusing on social support and the health-related quality of life among Korean American nursing home residents, ideas from the different theoretical paradigms presented earlier guide this researcher's explanation of the role of social support and health-related quality of life among Korean American nursing home residents. Based on the review of literature, a conceptual framework was created for this study (Figure 1). This conceptual framework includes variables that are found in various literary and scholarly sources, and examines social support and health-related quality of life indicators. It also describes and/or posits the relationship between the variables studied.

Research Questions

The primary purpose of this study was to examine the relationship between social support and health-related quality of life among Korean American nursing home residents. This study utilized a conceptual framework based on social exchange theory and the stress-coping paradigm framework. Based on the conceptual framework, the following specific questions were explored:

1. Are the dimensions of social support (source, duration, proximity, frequency, function, negative interactions, and subjective evaluations) associated with ADL impairments among Korean American nursing home residents?

2. Are the dimensions of social support (source, duration, proximity, frequency, function, negative interactions, and subjective evaluations) associated with depressive symptoms among Korean American nursing home residents?

3. Are the dimensions of social support (source, duration, proximity, frequency, function, negative interactions, and subjective evaluations) associated with self-rated health among Korean American nursing home residents?

4. Is there a mediating role for the social support dimensions upon the three health-related quality of life indicators of ADL impairments, depressive symptoms, and self-rated health among Korean American nursing home residents?

Hypotheses

Based upon the review and analyses of the extant literature, the following four hypotheses were tested to answer the above research questions:

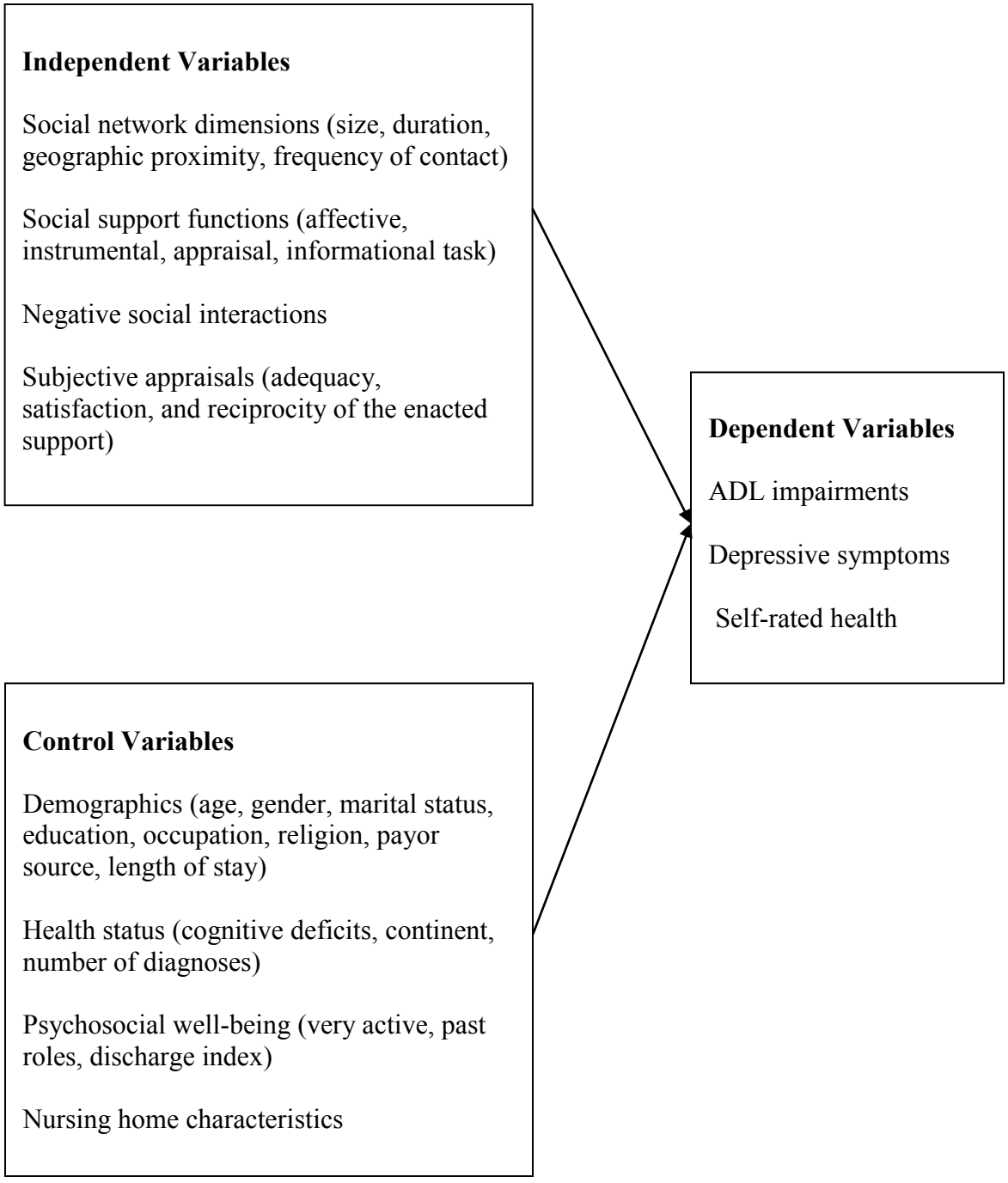
H1. After controlling for the covariates, social support is associated with the health-related quality of life indicators of ADL impairments among Korean American nursing home residents.

H2. After controlling for the covariates, social support is associated with the health-related quality of life indicators of depressive symptoms among Korean American nursing home residents.

H3. After controlling for the covariates, social support is associated with the health-related quality of life indicators of self-rated health among Korean American nursing home residents.

H4. There will be an interactive effect between the social support dimensions (source, duration, proximity, frequency, function, negative interactions, and subjective evaluations) and ADL impairments, depressive symptoms, and self-rated health among Korean American nursing home residents.

Figure 1: Conceptual framework of social support and health-related quality of life among Korean American nursing home residents



CHAPTER IV. RESEARCH METHODOLOGY

This chapter presents an overview of the research methodology employed in the study. The research design, sampling and selection of research subjects, measurement instruments (Minimum Data Set and Social Support Questionnaire), development and translation of the Social Support Questionnaire (SSQ), pilot testing phase of the SSQ, data collection procedures for both instruments, human subjects, and the data analysis strategy are detailed. The study employed a two-stage data collection process: a cross-sectional survey involving face-to-face interviews using the SSQ and data extraction from an existing dataset (MDS) with a sample of 73 Korean American nursing home residents.

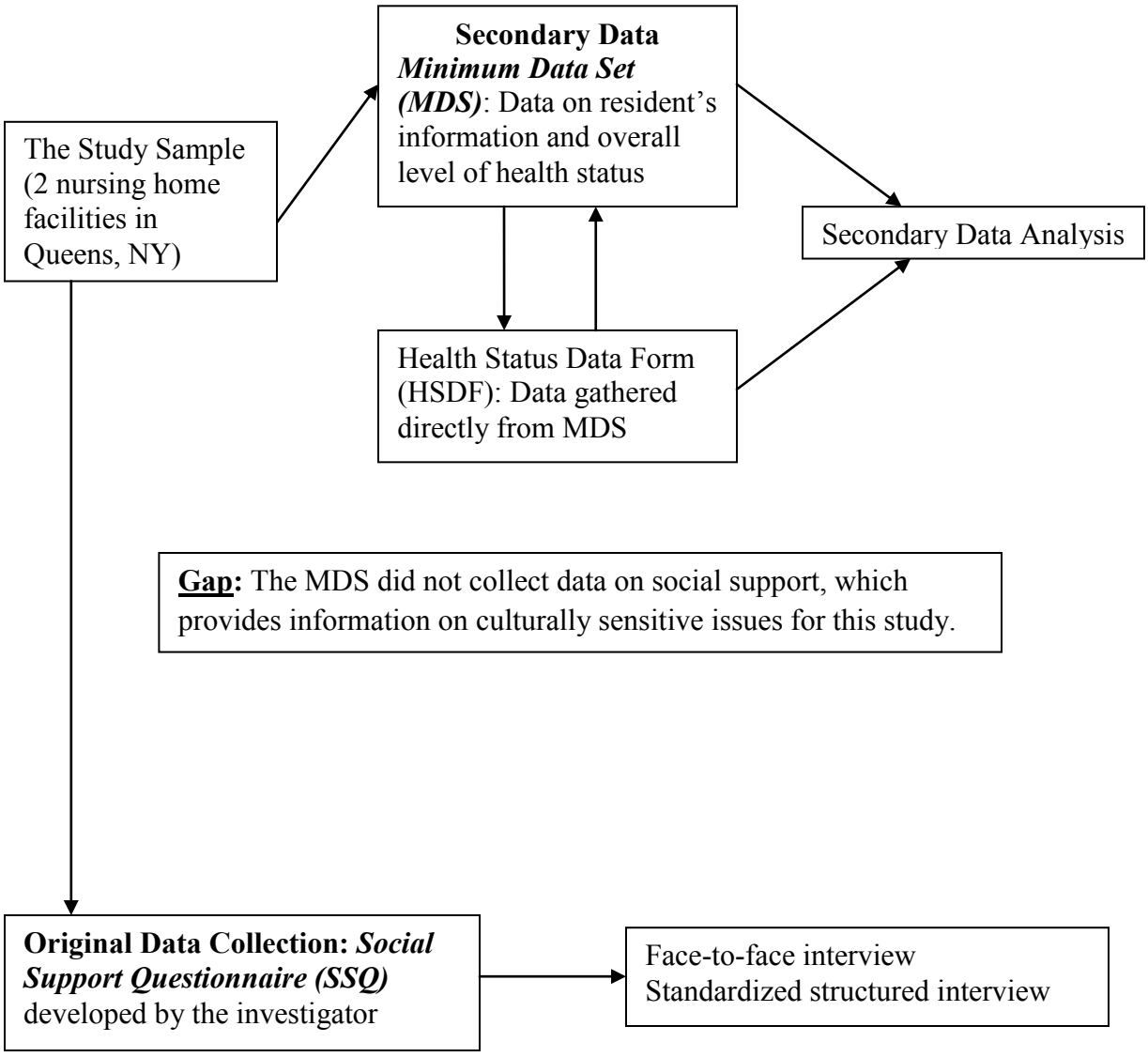
Research Design

A descriptive and exploratory mixed-method research design was employed in this study because its main purpose was to examine and understand the relationship between social support and health-related quality of life among Korean American nursing home residents. Based on this type of research design, a greater understanding of the characteristics of the variables, the relationships between the variables, and their interrelatedness was identified and addressed.

A cross-sectional survey design entails measurement of some characteristics in a defined group at a given point in time. In other words, it provides information about what individuals may want, feel, or believe at a given time. Therefore, the first phase of the

study utilized the SSQ administered by the researcher in a face-to-face interview with Korean American nursing home residents. The second phase included data extraction of these same residents from the MDS, which is the federally-mandated tracking form for nursing homes. The study included approaching two nursing homes in order to get access to the MDS, which has a wealth of data regarding the resident's general information and overall level of health status. This component comprised the secondary data analysis section of the dissertation. The MDS was initially considered as the main data collection strategy, however, it does not include all the items needed to study social support among the nursing home residents. A social support questionnaire was therefore, constructed by the researcher (see Appendix E) and social support data were collected via face-to-face interviews by this researcher. All participants who completed the SSQ and gave consent for the collection of their MDS data comprise the study sample from the two nursing homes. The algorithm that follows depicts the research design (Figure 2).

Figure 2: The Research Design



Selection of Research Subject and Sampling

Research Site Selection

Two nursing facilities with Korean American populations in Queens, NY, licensed as long-term care facilities by the State of New York, were targeted for the sample selection. However, the process of identifying and gaining access into nursing facilities with Korean American populations was not easy due to the limited availability of eligible subjects.

Two particular nursing homes in Queens, NY, were chosen as the setting for the study for three reasons: 1) the resident population is predominantly Asian American, including Korean American; 2) the researcher is familiar with the population and has observed Korean American residents and their daily routines in her prior work with this population; and 3) the researcher has a professional relationship with the nursing staff and social workers from both nursing homes.

Once two nursing homes were identified, the researcher sent a cover letter to the administrator of each nursing home, introducing the purpose of the study and seeking cooperation from the facility (see Appendix A). Two weeks after the cover letter was sent out, the researcher contacted the administrator of each nursing home to obtain permission to conduct the research. Although the administrators were concerned that the facilities might be identified and that the residents might think negatively of them for allowing a student to direct the interviews, the researcher was able to obtain permission from the administrators after sending an informed consent form, which included the purpose and the procedures of the study, research participants' rights, assurance of anonymity in

reporting on the findings, confidentiality, benefits, and related risks or discomforts. The researcher also explained the study's objective and reassured the administrators that the names of potential participants and facilities would not be used. Moreover, the researcher emphasized that all data gathered from this study would be kept confidential and that data would be used only for the purpose of this study. After receiving verbal permission from each of the two nursing home administrators by telephone, the researcher visited the nursing homes and obtained approval letters from each nursing home.

The Study Sampling Criteria

The study sample consisted of Korean American residents of nursing homes in Queens, New York. Inclusive criteria for the sample required that the subject be age 65 or older, Korean-speaking, capable of verbal communication, physically and mentally capable of participating in a face-to-face interview session, and cognitively capable of understanding and answering the questionnaire. Criteria that excluded the participant from the study were the following: a diagnosis of Alzheimer's disease; dementia other than Alzheimer's disease; organic brain syndrome; senility; traumatic brain injury; mental retardation; manic depression; psychoses; schizophrenia; a terminal condition; ; alcoholism/ETOH abuse; younger than age 65; and newly admitted to the facility. To select participants, the researcher contacted the administrator of each nursing home to ask for Korean American residents who met these criteria. The nursing home staff identified the residents who met these sampling criteria.

Participant Selection

The nursing home staff from the two nursing homes in Queens, NY, identified Korean American residents who met the sampling criteria. The total number of residents from the two nursing homes was 530. One nursing home facility has 280 beds, 78% (n = 218) of which were occupied by Korean American residents. The other nursing home facility has 250 beds, 25% (n = 63) of which had Korean American residents. These 281 Korean American nursing home residents in both facilities were evaluated for study participation (using the selection criteria outlined above) by a nursing supervisor or social worker within the two nursing homes. Forty one percent (n = 114) of a total Korean American nursing home resident population of 281 met the sampling criteria for the study.

The low number of eligible subjects can be attributed to the strict eligibility criteria. There were not many cognitively intact elderly currently residing in the two nursing homes. All 114 potential participants who met the study criteria were contacted for the study. The nursing supervisor/social worker in each nursing home facility distributed the study recruitment letter (see Appendix B), and consent forms (see Appendix C) were signed by residents who agreed to participate in the study. Out of 114, a total of 73 participants completed a face-to-face interview and another 16 were not available for contact due to hospitalization, transfer to another nursing facility, or death. The remaining 25 potential participants declined to participate or complete a face-to-face interview.

The sample size of 73 participants represents a 64 % response from the 114 eligible residents who fitted selection criteria at these two nursing homes. This response

rate was very high, considering the fact that a study of this nature has not been conducted in either of these two nursing homes before.

Prior to the face-to-face interview, a signed consent form was obtained from each study participant by the researcher. The consent form had prior IRB approval from the City University of New York, The Graduate Center Human Subjects Committee. Residents were provided with signed copies of the form.

Research Instruments and Measurement

As mentioned earlier in this chapter, the researcher used the Minimum Data Set (MDS) completed in the last 12 months by the nursing home and a social support questionnaire (SSQ) developed by the researcher. All those who consented to participate in the study agreed to be interviewed and to have their MDS data extracted. The SSQ was administered first. All 73 participants completed the SSQ. Following the completion of their SSQs, the researcher was given access to their MDS data by the nursing home administrators.

Minimum Data Set (MDS)

The Minimum Data Set (MDS) is the standardized assessment instrument required for all nursing home residents. The MDS instrument was federally-mandated in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) and went into effect in 1990. It is a uniform, standardized, and comprehensive assessment instrument for all residents, regardless of payer (Hawes, Morris, Phillips, Mor, Fries, & Nonemaker, 1995).

It represents an attempt to standardize information, monitor residents' status and progress, and improve quality of resident care.

There are two MDS scales: the full assessment and the quarterly assessment. The quarterly assessment is a subset of the MDS (full assessment) items and does not contain new data. There are two schedules for the MDS. According to federal mandate, the full MDS assessment is conducted upon admission, annually thereafter, and whenever a significant change in status has occurred. The quarterly assessment is conducted on a quarterly basis.

The MDS is a core set of items, definitions, and reseponse categories used to assess nursing home reisdents (Hawes et al., 1995). More than 250 items gather a wealth of data regarding the resident's demographics, customary routine, advance directives, cognitive patterns, communication and hearing patterns, mood and behaviors, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses, health conditions, nutritional status, oral and dental status, skin condition, activity pursuit patterns, medications, special treatments and procedures, discharge plans and overall status, and more. The instrument purposely addresses the special measurement challenges posed by the nursing home resident, whose functional abilities, communication skills, cognitive capaicities, mood patterns, and behaivors very during the day and across the week. (Hawes et al., 1995). Data are collected by trained nurses in consultation with professional and nonprofessional staff, the resident, the resident's family, and medical records.

Reports of the reliability and validity of the MDS show that it is adequate for research purposes. Inter-rater reliability has been found to be generally high (.75-.99)

(Casten, Lawton, Parmelee, & Kleban, 1998). Domains that achieved excellent reliability (.7 or higher) are identification and background, physical functioning (ADLs) and structural functioning, disease diagnoses, oral/nutritional status, and medication use. An average reliability of .6 was found in the domains of vision and customary routines. Six other domains demonstrated a reliability of .5 to .59, and five domains demonstrated .4 to .49 reliability (Hawes et al., 1995).

A confirmatory factor analysis showed a high factor pattern validation for cognitively intact residents, but not for impaired residents (Casten et al., 1998). Another study reported ADL functioning, cognition, and communication scores correlated well with independent scales; behavior scored modestly and mood scores were poor (Frederiksen, Tariot, & De Jonghe, 1996).

Within the domain of psychosocial well-being, the subscale of "sense of initiative/involvement" was tested separately for reliability and construct validity (Mor, Branco, Fleishman, Hawes, Phillips, Morris, & Fries, 1995). The subscale tested is identical to the one used in the dissertation study. The authors reported reasonable internal consistency (Cronbach's alpha = .79). A confirmatory analysis suggested that the measure was conceptually distinct from similar resident characteristics, including behavior, mood, and conflicted relationships.

Health Status Data Form

The instrument utilized in this study to collect data from the MDS in the medical record is called the Health Status Data form (see Appendix D). The health status data form duplicates the MDS item sequence, scales, items, operational definitions, and

coding. Since the MDS is a complex data form that collects a large amount of data, a simplified form of the MDS is also used by the nursing homes to capture data on health status. This health status data form is essentially similar to the MDS, but it has medical data that is designed to facilitate data gathering directly from the MDS. The health status data form enabled the researcher to extract from the MDS those variables that are specific to the study.

Domains selected for inclusion in the current study are those relevant to the study hypotheses, and include identification information, demographic information, customary routine, identification and background information, cognitive patterns, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses, health conditions, oral/nutritional status, skin condition, activity pursuit patterns, medications, special treatments and procedures, discharge potential and overall status.

Social Support Scales

An extensive search of the long-term care literature was conducted to locate a relevant social support scale. Social support has been examined through an anthropological fieldwork approach (Powers, 1988) and qualitative interviews (Grau, Chandler, & Saunders, 1995). The social support scales designed for nursing home populations were not sufficiently comprehensive for this study's purpose (Hebrew Rehabilitation Center for Aged, 1980; Kahana et al., 1985; Reed & Washington, 1984; Research Institute of the Hebrew Home of Greater Washington, 1990).

Although many studies yield a multitude of social support scales, general population scales are rarely administered to nursing home populations (Barrera, Sandler, & Ramsay, 1981; Krause & Markides, 1990; Sarason, Levine, Basham, & Sarason, 1983; Stansfield & Marmot, 1992). Only one study was found in which a well-known instrument, the "Perceived Social Support from Friends' (PSS-FR) and "Perceived Social Support from Family" (PSS-FA) (Procidano & Heller, 1983) was administered to a nursing home sample. The PSS-FR and PSS-FA measure the perceived fulfillment of emotional support, information, and feedback provided by friends and family. The authors encountered problems unique to the study populations: 70% of the respondents reported that they had no friends and 19% had no family (Commerford & Reznikoff, 1996). This finding may be indicative of the obstacles encountered when applying general social support scales to a nursing home population.

Four general population social support scales are relevant to the scale design and item generation of the present study instrument. The instruments are: 1) the Inventory of Socially Supportive Behaviors (ISSB), a 40-item scale by Barrera et al., (1981); 2) the 41-item Social Support Scale by Krause and Markides (1990); 3) a 100-item scale by Shuttlesworth, Rubin, and Duffy (1982); and 4) the Norbeck Social Support Questionnaire, a 9-item scale by Norbeck and her colleagues (1981, 1983).

The ISSB measures four social support functions (emotional, instrumental, appraisal, and information). It has been tested for reliability (test-retest correlation coefficients 0.882 and internal consistency coefficient alpha 0.93) and validity (r =.36) (Barera et al, 1981). The Krause and Markides scale is a further adaptation of the ISSB. It includes reciprocity and perceived satisfaction with support. It is a brief instrument (41

items) and has been tested for scale factor structure (critical N value of 205.81), internal consistency (alpha and omega coefficients) and validity. The instrument by Shuttlesworth and her colleagues (1982) was utilized for its list of informational tasks. The scale consists of 100 technical and nontechnical tasks occurring in a nursing home setting. It is used to identify role expectations of families and nursing home administrators. The Norbeck Social Support Questionnaire is uniquely designed to capture the specific contributions of each network member. This design can be cumbersome with large social networks but yields much information for smaller networks.

The Social Support Questionnaire: Instrument Design and Item Generation

The social support scales mentioned above, however, do not adequately measure social support in a way that would capture what the researcher needed for this study. For this reason, the researcher developed a social support questionnaire that is culturally sensitive to the study population (see Appendix E).

The instrument developed by this researcher (the social support questionnaire) was to be administered in private and estimated to be completed in 30-45 minutes. It was developed according to the broad outline sketched by Payne and Jones (1987), which identifies five facets of instrument design: source, content, disposition, description/evaluation, and direction of support (see Table 1).

Table 1: Items on the Social Support Questionnaire

Dimension	Measure	Item#
Social network		
Size	Number of important persons	10, 11
Strength/relationships	Relationships of important persons	12, 37
Duration	Length of time known	13, 38
Geographic proximity	Distance to nursing home	14, 39
Mode of contact	Visit, phone, or mail	15, 18, 21, 40, 43, 46
Frequency of contact	Frequency of visit, phone, or mail contacts	16, 19, 22, 41, 44, 47
Pattern of contact	Pattern to visit, phone, or mail contacts	17, 20, 23, 42, 45, 48
Social support functions/contents		
Task or function	Emotional/affective task Informational task Appraisal task Instrumental task	24-25, 49-50 26-27, 51-52 28-29, 53-54 32-33, 57-58
Negative social interactions	Being upset, being hurt	30-31, 55-56
Direction of support		
Symmetry	Reciprocity between participant and network member	34, 59
Subjective appraisals		
Perceived adequacy	Subjective evaluation of having sufficient support	35, 60
Perceived satisfaction	Subjective evaluation of satisfaction with support	36, 61
Perceived control	Subjective evaluation of having sufficient control over one's life in nursing home	62
Self-rated health	Subjective rating of overall health in nursing home	63
Children in the community		
Living adult children	Living adult children	64
Number of living children	Number of living children	65

Table 1: *(continued)*

Dimension	Measure	Item#
Geographic proximity of adult children	Proximity to nursing home	66-70
Environmental/ Social change		
New room	Recent change in room	4
New roommate	Recent change in roommate	5
Loss of friends or family	Recent loss of close friend or family	6, 7, 8
Telephone ownership	Ownership of private telephone	9

Source of support includes identification of the network member, relationship, duration of tie, geographic proximity of the network member to the nursing home, and mode and frequency of contact. *Content of social support* includes emotional, information, appraisal, and instrumental functions. *Disposition of social support* means both perceived and enacted support. A *description of social support* includes the quality and nature of the behaviors. *Direction of support* means the balance of helping behaviors between self and specified network members.

In short, the dimensions of the social support questionnaire (SSQ) include size, strength, duration, geographic proximity, mode of contact, frequency of contact, pattern of contact, task of function, negative social interaction, symmetry, perceived adequacy, perceived satisfaction, perceived control, self-rated health, living adult with children, number of living children, geographic proximity of adult children, new room, new roommate, loss of friend or family, and telephone ownership.

The SSQ is designed to measure separately the amount and type of support received from each important person. The social support variables are recoded according

to the number of support persons who performed or provided specific support. The variables are interpreted as the number of support persons who scored as follows: being an immediate family member; being an extended relative; having a relationship with the subject for five years or more; residing less than 25 miles from the nursing home; visiting; having phone contact; having mail contact; being affectionate; listening; advising; updating; accepting; complementing; upsetting; performing errands; managing finances; hurting; having a symmetrical relationship with the subject; providing sufficient support to the subject; and providing satisfactory support to the subject. The recoded social support variables are all nominal variables and are scored from 0 – 1. The full listing of study variables may be found in Table 2.

Table 2: Operationalization of Study Variables: The SSQ

Variables	Description	Instrument
Social Support		
Person 1	Important person 1 in one's life (yes/no)	SSQ
Person 2	Important person 2 in one's life (yes/no)	SSQ
Immediate family	Number of support persons from immediate family	SSQ
Relatives	Number of support persons from extended relatives	SSQ
Adult children	Number of living children	SSQ
Duration	Number of support persons known 5 + years	SSQ
Geographic proximity	Number of support persons residing < 25 miles away	SSQ
Frequency of visitation	High to low (0-4)	SSQ
Frequency of phone contact	High to low (0-4)	SSQ
Frequency of mail contact	High to low (0-4)	SSQ
Affection	Number of support persons providing affection (0-1)	SSQ
Listen	Number of support persons listening to subjects (0-1)	SSQ
Advice	Number of support persons giving advice (0-1)	SSQ
Update	Number of support persons updating subject (0-1)	SSQ
Accept	Number of support persons giving acceptance to subject (0-1)	SSQ
Compliment	Number of support persons complimenting subject (0-1)	SSQ
Errands	Number of support persons running errands for subject (0-1)	SSQ
Finances	Number of support persons managing finances for subject (0-1)	SSQ
Hurt	Number of support persons hurting subject (0-1)	SSQ
Upset	Number of support persons upsetting subject (0-1)	SSQ
Symmetry	Subjective evaluation of number of symmetrical relationships (0-3)	SSQ

Table 2: *(continued)*

Variables	Description	Instrument
Social Support		
Adequacy	Subjective evaluation of number of adequate relationships (0-3)	SSQ
Satisfaction	Subjective evaluation of number of satisfactory relationships (0-2)	SSQ
Socially engaged	8 items on "sense of initiative/involvement" (0-1)	MDS
Unsettled relationships	9 items on "unsettled relationships" scale (0-1)	MDS
Environmental change	Recent change in room and/or roommate (yes/no)	SSQ
Own telephone	Yes/no	SSQ
Perceived control	Subjective evaluation of sense of control over one's life (enough/not enough)	SSQ
Frequency X Negativity	Interaction term	SSQ
Frequency X Perceived control	Interaction term	SSQ
Negativity X Perceived control	Interaction term	SSQ
Demographic		
Age	In years	MDS
Gender	Male/female	MDS
Marital Status	5 categories	MDS
Education	8 categories	MDS
Occupation	12 categories	MDS
Religion	5 categories	MDS
Payor	Participant's source of payment; 10 categories	MDS
Length of stay	Number of days since admission	MDS
Health Status		
Cognitive deficits	Yes/no	MDS
Continent	Yes/no	MDS
Number of diagnoses	Score 0-5	MDS
Psychosocial well-being		
Very active	Dummy variable activity level > 1/3 times	MDS
Past roles	5 items on "past roles" scale (yes/no)	MDS
Discharge index	3 items on "discharge potential" scale (0-3)	MDS

Table 2: *(continued)*

Variables	Description	Instrument
Dependent Variables		
ADL impairments	Total number of impairments in 5 ADL functions: bathing, dressing, toileting, transferring, and eating (0-5)	MDS
Depressive symptoms	Presence of indicators of depression (none; 1 or more)	MDS
Self-rated health	Subjective evaluation of overall health on 4-point scale	SSQ

*** SSQ = Social Support Questionnaire
*** MDS = Minimum Data Set

Identification of Independent and Dependent Variables

Independent Variables

The literature and previous research studies were used to identify relevant independent measures for this study. The major independent variable is social support. Social support is operationalized according to the following: 1) social network size, duration, geographic proximity, and frequency of contact; 2) social support functions of emotional/affective, informational, appraisal, and instrumental tasks; 3) negative social interactions; and 4) subjective appraisals of the adequacy, satisfaction and reciprocity of the enacted support. In addition, other study variables include 1) demographics, such as age, gender, marital status, education, occupation, religion, payor, and length of stay; 2) health-cognitive deficits, bowel and bladder continence, and number of medical/psychiatric diagnoses; and 3) psychosocial-activity, past roles, and discharge index. Table 2 shows the independent variables and their operational definitions.

Dependent Variables

Review of the literature and previous research identified dependent measures for this study. Three dependent variables were selected from among the many health variables: ADL impairments, depressive symptoms, and self-rated health. They were selected because they reflect the quality of life of Korean-American nursing home residents. ADL impairments describe the day-to-day functioning of the individual; depressive symptoms provide affective indicators; and self-rated health offers insight into the subjective experience of health.

Translation of the Social Support Questionnaire (SSQ)

Since participants were Korean American elderly who migrated to the United States in their later age, the majority of participants have difficulty reading or understanding the English language. Therefore, the SSQ was translated into Korean before the survey could be administered to Korean American nursing home residents.

There are three stages for translation to ensure translation equivalence, linguistically and culturally. First, the research instruments were translated from English into Korean by the researcher. Second, the transcribed Korean versions were translated back into English by a different translator. Both the translator and back-translator are highly-educated and fluent in Korean and English. In order to check for consistency, the first and second English versions were compared to ensure accuracy of content.

Back-translation is a recommended procedure for cross-cultural researchers (Brislin, 1986; Brislin, Lonner, & Thorndike, 1973). The major advantage of back-

translation is that it gives researchers some control over the instruments' development because they can examine original and back-translated versions and make inferences about the quality of the translation (Brislin, 1986).

The researcher was initially concerned that all Korean-speaking residents would not fully understand the instrument. To ensure that the SSQ was comprehensible to participants, the English version of the questionnaire was put into a colloquial form that would be understood by people with little formal education. This proved to be a difficult task. The challenge was to adapt the instrument in a culturally relevant and comprehensible way while maintaining the meaning of the original items (Sperber, Devellis, & Boehlecke, 1994).

There were three major issues regarding the translation from English into Korean: 1) grammar is different in Korean compared with English; 2) some English concepts do not have matching items in Korean, and 3) sentence construction is different in Korean, so most of the sentences had to be reorganized. The difference in sentence structure in Korean in many cases has to do with cultural differences. Some concepts in English instruments are not familiar to most Korean people, and it was difficult, therefore, to find matching items. Some concepts from existing social support instruments are not culturally sensitive to Korean people, and the SSQ was developed specifically to address this shortcoming and constructed in such a way as to ensure comprehension by study participants.

All the items in the SSQ are short sentences, and both the translator and back translator are familiar with colloquial terms used by Korean Americans. To ensure comprehension and cultural sensitivity to Korean languages, two bilingual professionals

(not previously involved in the translation of the QSS) were consulted. This process ascertained that the items are culturally valid, and conceptually and linguistically consistent. The professionals agreed that the original and translated versions of the SSQ were correct and culturally sensitive.

Pilot Testing Phase

Like any single method or approach, back translation is no panacea (Brislin, 1986). All materials should be pretested with respondents similar to those in the proposed main sample (Brislin, 1986). Pilot testing can help clarify any misinterpretations in the wording of the questions, reduce offensive items that may annoy participants, and check the time required to complete the instruments. It also helps determine reliability and validity.

The pilot testing was conducted with two bilingual staff and two selected Korean American nursing home residents. Those two residents used for the pilot testing were not included as a part of the final study sample. They were asked to think about a concept and then asked to reflect upon it from the viewpoint of one's culture, and the other (Brislin, 1986). Based on the feedback from this pilot test, revisions were generated to ensure fewer problems with, and better measurement of, social support among this Korean American nursing home population.

Data Collection Procedure

Data were collected after obtaining: 1) IRB approval of the research involving human subjects by The Graduate Center Human Subjects Committee, of the City University of New York; 2) approval from the nursing homes to identify and gain access to the resident population; and 3) signed informed consent from study participants.

Upon gaining approval of appropriate authorities of the nursing homes, the researcher visited each nursing home and attended a monthly resident council meeting. During the meeting, the researcher introduced herself to the residents of each nursing home and explained the purpose, procedures, and importance of the study. In addition, study participants' rights, assurance of anonymity, the confidentiality of their participation, benefits, and related potential risks or discomforts were fully explained to the residents.

After being informed of eligible participants for the study by the nursing home staff, the researcher visited the potential participants for the study and distributed the recruitment letter individually to them. The recruitment letter briefly introduced the researcher, and explained the purpose of this study as well as procedures and the expected time for the interview. When the researcher visited the nursing homes, only the ones who were interested in participating in the study made an appointment with the researcher. The researcher explained the propose of the study, the procedures, the kinds of questions to be asked, confidentiality of data, anonymity of participation, the length of time required for the face-to-face interview (approximately 30-45 minutes), their options

to withdraw at any time during the process or to refuse to answer any questions, and the voluntary nature of their participation. All information was provided in Korean.

In terms of the use of the social support questionnaire, participants were also advised that: 1) it is important to obtain precise information from them; and 2) if any of them had difficulties remembering facts and/or their experiences, they could refuse to answer any questions. When they agreed to participate in the study, the informed consent form was signed.

Data were collected by the individual administration (via face-to-face interviews) of the self-rating social support questionnaire. One of the advantages of self-rating scales is that participants do not need to disclose sensitive information directly to the interviewer. In addition, the interviewer's personality and behavior do not influence the questionnaire results. However, with the elderly population, self-administered scales may have some drawbacks. In addition to the well-known disadvantage of self-rating scales such as a response biased by misunderstanding and visual impairments, which are common to the elderly population, self-administration may further prevent completion of the questionnaire. Given these factors, the researcher conducted face-to-face interviews based on the developed SSQ to help participants complete the survey. The benefits of the face-to-face interview were that a participant could clarify the nature of questionnaire being asked. It could also help clarify confusion over survey questions being asked. In addition, face-to-face interviews were an efficient way to elicit information from frail elders with visual impairments or minimal literacy. For example, when a participant was able to read the questionnaire written in Korean, the participant was encouraged to ask questions whenever he or she experienced a difficulty understanding the question. Then,

the researcher provided a further explanation of the meaning of the question. When a participant had a limitation in reading the questionnaire, the researcher read each item of the questionnaire for the participants and filled in the response with the participant. In addition, the print of the questionnaire was generally large enough (letter size 14 in word) for the participant to read easily, because size 14 is recommended for the visually impaired (Valleman, 1990).

Human Subjects Considerations

Before the interview began, the participants were required to review the informed consent form written in Korean. The researcher offered to read the consent form to each participant to ensure that those who could not read were able to fully understand the content of the consent form. The participants were informed that the interview would last 30-45 minutes and be conducted at a time and place of their preference; that they were under no obligation to participate; that they could withdraw from the interview at any time without penalty and refuse to answer any questions; that all study results and their responses would be processed in a manner to protect anonymity and confidentiality; and that there would be no compensation for participating in this study. Once they understood the purpose of the study and expressed a willingness to participate, they were asked to sign the informed consent form. Participants received a copy of the consent form.

Although there were minimal risks to participation in the study, some unforeseen results could occur during the interview, including the participant's tiredness or distress and feeling discomfort or embarrassment with some questions. The participants were

fully informed that that they could have a short break during the interview. In addition, nursing staff at the facilities could be informed immediately if participants showed any physical or mental issues during the interview. However, none of the participants reported or experienced physical or mental problems requiring immediate attention from nursing staff during the interview.

In terms of protecting anonymity and confidentiality to the study participants, the researcher informed the participants that no personal identifiers would be linked to the data. In addition, the records would be kept in a locked filing cabinet in the researcher's office and all electronic data would be stored on the researcher's personal computer, which is password protected. The study participants were made aware that the information would be stored for a minimum of three years, after which all the materials would be destroyed. The participants received contact information for the researcher, faculty advisor, and IRB office to address any concerns or issues related to the study.

Data Analysis Strategy

The purpose of the data analysis for this study was to examine the relationship between social support and health-related quality of life among Korean American nursing home residents. The data analysis was comprised of three steps. First, univariate analysis was used to describe and characterize the study sample. Second, bivariate analysis was utilized to describe critical variables in the study and test the relationships between these variables. Tests were conducted to identify interactive effects among selected independent and dependent variables. Bivariate analysis was conducted using statistical

tests as appropriate, including Pearson correlation (two-tailed test), Spearman correlation (two-tailed test), one-way ANOVA, and independent-samples T test (Kachigan 1986). In the final step, multiple regression analysis and Multivariate Analysis of Covariance (MANCOVA) were used to test the research hypotheses. In other words, multiple regression analysis was used to explain the contribution of social network and social support to the health-related quality of life dimensions of ADL impairment, depressive symptoms, and self-rated health. The regression models were built with variables presenting both theoretical and statistical significance. MANCOVA was used to assess the relationship between the independent and dependent variables, while controlling for specific demographic variables, health-cognitive deficits, and medical/psychiatric diagnoses.

CHAPTER V. RESULTS

Data gathered for the full sample (n = 73) were entered into SPSS 19. Descriptive, bivariate, and multivariate analyses were conducted using SPSS 19.

The first phase of data analysis involved cleaning up the raw data and transforming variables as needed in preparation for hypothesis testing. The tasks performed were: 1) identifying missing values; 2) recording variables; 3) transforming original variables into new variables; and 4) examining the data using frequency distributions and descriptive statistics for the accuracy of the data, data entry errors, and mathematical inconsistencies. The second phase of the analysis was to conduct the univariate analysis of the study sample, which included a review of participant demographic characteristics, health and program utilization, social network dimensions, social support behaviors, and psychosocial well-being variables. The bivariate analysis of all the variables was also conducted. This phase included: 1) testing for significant relationships between the dependent variables, and the independent and control variables; and 2) testing for interactive effects among selected independent and control variables and the dependent variables. In the final stage, regression models were built and performed for testing the primary research hypotheses. Multiple regression and Multivariate Analysis of Covariance (MANCOVA) were used to assess the relationship between the independent and dependent variables while controlling for moderating or mediating variables.

Descriptive Data Analysis

Demographic Characteristics

As observed in Table 3, the study participants (n = 73) consisted of 50 females (68.5%) and 23 males (31.5%). There was a 31- year range in ages, from ages 69 to 100, with a mean age of 86.82 years (SD = 8.81). Almost two-thirds (65.8%) of the respondents were 85 years or older and more than three-quarters (76.7%) were widowed. The majority of the participants did not complete college (n = 60, 82.1%) and almost half (43.8%) identified themselves as homemakers prior to their admission to the nursing home. In terms of religious affiliation, 65.8% of the respondents identified as Christian/Protestant and more than half indicated that they did not live alone (n = 40, 54.8%) prior to being admitted to the nursing home. The majority reported that they had children who were still alive (n = 67, 91.8%). Sixty two percent also indicated that they had at least one child who lived within 25 miles of the nursing home they were in.

In summary, the nursing home participants in this study were predominantly female, within the "oldest old" (Berkman & D'Ambruoso, 2006; Hooyman & Kiyak, 2008) segment of the aging population, without college degrees, primarily Protestant and with children living fairly close to the nursing home.

Table 3: Demographic Characteristics of the Study Participants (N = 73)

Variable	N	%
Gender		
Male	23	31.5
Female	50	68.5
Age		
65-74 years	9	12.3
75-84 years	16	21.9
85+ years	48	65.8
Marital Status		
Never married	2	2.7
Married	10	13.7
Widowed	56	76.7
Separated	1	1.4
Divorced	4	5.5
Education		
No schooling	15	20.5
8^{th} grade or less	20	27.4
9^{th} to 11^{th} grades	8	11.0
High school	12	16.4
Some college	5	6.8
Bachelor's degree	11	15.1
Graduate degree	2	2.7
Lifetime Occupation		
Executive/professional	14	19.2
Sales/technical support	9	12.3
Service industry	4	5.5
Skilled work	3	4.1
Semi-skilled work	3	4.1
Transportation	1	1.4
Laborer	4	5.5
Farming	2	2.7
Military	1	1.4
Homemaker	32	43.8

Table 3: *(continued)*

Variable	N	%
Religious Affiliation		
None	3	4.1
Catholic	18	24.7
Christian/Protestant	48	65.8
Buddhist	4	5.5
Any Living Children		
Yes	67	91.8
No	6	8.2
Lived Alone		
No	40	54.8
Yes	24	32.9
In other facility	9	12.3
Geographic Proximity of Children		
No children less than 25 miles	22	30.1
At least 1 child less than 25 miles	45	61.6
Missing	6	8.2

Health and Program Utilization

Health Utilization

Table 4 shows the health indicator variables as captured through the health status data from the MDS and SSQ. All respondents reported that their *long-term memory* was intact and (67.1%, n = 49) indicated that their *short-term memory* was okay. More than half of the respondents also indicated that they were relatively independent in terms of their cognitive skills for daily decision-making.

For mood patterns, 35.6% (n = 26) of the participants exhibited 1-5 indicators of depression, anxiety, or sad mood and 37% (n = 27) exhibited 6-10 indicators of depression, anxiety, or sad mood. The highest possible score for indicators of depression, anxiety and sad mood was 16, with higher scores representing greater depression, anxiety, or sadness. The mean mood score was 4.37 (SD = 3.29). The most frequently

found indicators of depression, anxiety and sad mood among the participants were: expressions of making negative statements (n = 51, 69.9%), self-deprecation statements (n = 51, 69.9%), sad, pained, worried facial expressions (n = 45, 61.6%), repetitive health complaints (n = 34, 46.6%), insomnia (n = 33, 45.2%), persistent anger with self or others (n = 22, 30.1%), crying or tearfulness (n = 17, 23.3%), unpleasant mood in the morning (n = 17, 23.3%), repetitive anxious non-health related complaints (n = 14, 19.2%), expression of unrealistic fears (n = 10, 137%), repetitive verbalization (n = 7, 9.6%), and recurrent statements (n = 7, 9.6%). In terms of receiving any psychotropic medications, 47.9% of the respondents took at least one or two psychotropic drugs. Among the respondents who took psychotropic medications, 43.8% took anti-depressant medication while 12.3% took anti-anxiety medications. In addition, 35.6% of the respondents received psychological therapy for mood symptoms. The incidence of behavioral symptoms, such as wandering, verbally or physically abusive behavior, socially inappropriate behavior, and resisting care was extremely low.

The participants experienced impairments in all of the following five major activities of daily living (ADLs). The percentage of participants with impairments was: 97.3% (n = 71) bathing; 87.7% (n = 64) dressing; 89% (n = 65) transferring; 91.8% (n = 67) toileting; and 57.5 (n = 42) eating. The highest possible ADL score for each of the five impairments was four, with higher scores indicating greater dependence. The mean ADL score for study participants on the above mentioned impairments was 2.48 (SD = 0.72). In addition to the five major ADL impairments, participants also reported on the following three impairments: 1) walking in room; 2) walking in corridor; and 3) personal hygiene. In order to arrive at a numeric total score for all eight ADL impairments, the

scores for each ADL impairment were added, thereby creating a possible total score of 4-32 for each participant. Thirty two percent of the respondents (n = 23) had total ADL scores ranging from 21 to 25, and 26% (n = 19) of the respondents had an ADL score of 26 or more. The participants experiencing impairments required various forms of assistance, ranging from limited assistance to total dependence in major activities of daily living.

In terms of bowel and bladder continence, 47 participants (64.4%) were continent in both bowel and bladder. The highest possible continence score was four, with higher scores indicating incontinence. The mean continence score was 1.08 (SD = 1.36). Seventy percent (n = 51) of the respondents did not experience falls or fractures in the past six months. In terms of weight loss, 80.8% of the respondents (n = 57) did not have any weight loss in the past six months.

The respondents presented with a large variety of physical and mental health diagnoses; some chronic and others non-chronic: 4.0% (n = 3) had 1-2 diagnoses; 26.1% (n = 19) had 3-4 diagnoses; and 69.9% (n = 51) had five or more diagnoses. The highest possible number of diseases respondents could have was 43. The mean number of diagnoses was six (SD = 3.06), indicating relatively few diagnoses among this nursing home population. The most frequently found diagnoses among the respondents were: hypertension (n = 55, 75.3%), osteoporosis (n = 43, 58.9%), depression (n = 36, 49.3%), diabetes mellitus (n = 29, 39.7%), cataracts (n = 27, 37.0%), cerebrovascular accident (n = 25, 34.2%), arthritis (n = 23, 31.5%), anemia (n = 22, 30.1%), hip fracture (n = 17, 23.3%), hemiplegia/hemiparesis (n = 17, 23.3%), and congestive heart failure (n = 18, 24.7%).

In terms of average time involved in the pursuit of activities (which included a wide range of activity preferences such as playing cards, being involved in crafts, exercise/sports, music, reading and writing, and so on—see Appendix D, Section N, p. 200), the majority of the respondents participated in activities more than one third of the time (n = 54, 72.6%). More than two thirds (68.5%) of the participants also felt that they had enough control over their life in the nursing home and their overall health was fair or good (n = 55, 75.4%).

In summary, the respondents in this study have good memory, with fairly low indicators of depression, anxiety and sad mood. Almost half were however, taking one or two psychotropic medications and utilized psychological services. Although a substantial proportion experienced five of the major ADL impairments, most had good bladder and bowel continence, relatively few physical and mental health diagnoses, and were reasonably active within the nursing home.

Table 4: Health Characteristics of the Study Participants (N = 73)

Variable	N	%
Short-term Memory		
OK	49	67.1
Problem	24	32.9
Long-term Memory		
OK	73	100.0
Cognitive Skills for Daily Decision-making		
Independent	49	67.1
Modified independence	24	32.9
Depression, Anxiety, or Sad Mood Indicators		
Zero indicator	18	24.7
1-5 indicators	26	35.6
6-10 indicators	27	37.0
11+ indicators	2	2.7
ADL Impairments		
Bathing	71	97.3
Dressing	64	87.7
Toileting	67	91.8
Transferring	65	89.0
Eating	42	57.5
Total ADL Scores		
10 or less	0	2.7
11-15	10	13.7
16-20	19	26.0
21-25	23	31.5
26 or more	19	26.0
Continence in Bowel and Bladder		
Incontinent in both bowel and bladder	26	35.6
Continent in both bowel and bladder	47	64.4
Number of Diagnoses		
One	2	2.7
Two	1	1.4
Three	8	11.0
Four	11	15.1
5 or more	51	69.9

Table 4: *(continued)*

Variable	N	%
Accidents		
None	51	69.9
Fell in past 30 days	7	9.6
Fell in past 30 to 180 days	14	19.2
Hip fracture in last 180 days	1	1.4
Weight Loss 5% or 10%		
No	59	80.8
Yes	14	19.2
Weight Gain 5% or 10%		
No	73	100.0
Psychotropic Medications		
None	38	52.1
One	21	28.7
Two	14	19.2
Special Treatments/Psychological Therapy		
No	47	64.4
Yes	26	35.6
Average Time Involved in Activities		
Less than 1/3 of time spent	20	27.4
More than 1/3 of time spent	53	72.6
Control Over Life in Nursing Home		
Enough	50	68.5
Not enough	21	28.8
Don't know	2	2.7
Self-Rated Health		
Poor	18	24.7
Fair	37	50.7
Good	18	24.7
Excellent	0	.0

Program Utilization

Table 5 describes the program utilization variables of the study. The program utilization variables include the primary source of payment and the lengths of stay of participants in the nursing home. In terms of payment source, all the participants used

Medicaid per diem to pay the nursing homes and 10 participants (13.7%) also used Medicare per diem. The respondents spent between two and 16 years in nursing homes; the mean number of years for the sample was 4.74 (SD = 3.54). The majority of the respondents (72.6%) had been living in the facility for one to five years.

In summary, the source of payment for residing in the nursing home for the majority of the participants was Medicaid per diem and their average length of stay was similar to nursing home residents in general (Dey, 1997).

Table 5: Program Utilization of the Study Participants (N = 73)

Variable	**N**	**%**
Medicaid per diem	73	100.0
Medicare per diem	10	13.7
Private pay	0	0.0
Other	0	0.0
Number of Years in Current Facility		
1-5 years	53	72.6
6-10 years	14	19.2
11 + years	6	8.2

Social Network Dimensions

Table 6 presents the social network dimensions of the study participants. Participants were asked in the SSQ to think about one or two of the most important persons in their life currently. Respondents were limited to selecting two persons.

All of the participants had at least one important person in his/her life and 60 participants were able to identify another important person in his/her life.

Person 1

The majority of the respondents (76.7%) indicated that their primary source of social support was either a daughter or a son. Seventy percent reported that this person lived within 25 miles of the nursing home, and almost all of them (95.9%) reported that their children visited them. As shown in Table 6, the children visited frequently, with some visiting daily (n = 16, 21.9%). Others, however, reported an irregular pattern of visits by their children, with 67.1% visiting sporadically. The majority of the respondents (75.3%) spoke on the phone with their primary source of support about one to three times a week (n = 37, 50.7%). The pattern of calls tended to be irregular for most respondents (75.3%). A minority of the respondents (8.2%) reported that their primary source of support sent letters or cards a few times a year; the pattern of letter-writing also tended to be irregular (6.8%). The majority of the respondents (84.9%) indicated that their primary source of support was more giving (in terms of reciprocity) than they themselves were. Close to half (47.9%) of the respondents stated that they received about the right amount of support and 39.7% indicated that they received more than enough support from their support person. The majority (83.6%) indicated that they were satisfied with the support they received.

Person 2

Almost two thirds (61.6%) of the respondents indicated that their secondary source of social support was either a daughter or a son (n = 45, 61.6%). Forty three percent reported that this person lived within 25 miles of the nursing home and 72.6% of the participants noted that this person visited them either one to three times a week (n =

25, 34.2%) or one to two times a month (n = 18, 24.7%). Fifty six percent of the respondents reported that the pattern of visits also tended to be irregular. Fifty nine percent of the respondents spoke on the phone with their secondary source of support about one to three times a week or one to two times a month. The pattern of calls also tended to be irregular, with 60.3% reporting that their secondary source of support called infrequently. A minority of the respondents reported that their secondary source of support sent letters or cards (n = 13, 17.8%) a few times a year (n = 11, 15.1%). The pattern of letter writing also tended to be irregular. More than half of the respondents (54.8%) indicated that their secondary source of support was more giving than they themselves were. More than half: 53.4% also stated that they received about the right amount of support and 54.8% indicated that they were satisfied with the support they received. A minority (21.9%), however, indicated that they were dissatisfied with the support they received from their secondary source.

In summary, most of the respondents indicated that they have someone important in their life, with children being the most important source of support. Support persons resided within close proximity to the nursing home and contact with the nursing home residents was quite frequent.

Table 6: Social Network Dimensions of the Study Participants

Variable	Person 1 (N =73)		Person 2 (N = 60)	
	N	%	N	%
Relationship				
Husband	2	2.7	3	4.1
Wife	8	11.0	1	1.4
Son	29	39.7	13	17.8
Daughter	27	37.0	32	43.8
Son-in-law	1	1.4	1	1.4
Daughter-in-law	0	.0	4	5.5
Grandchildren	0	.0	3	4.1
Sister	0	.0	1	1.4
Brother	2	2.7	1	1.4
Niece/Nephew	2	2.7	0	.0
Clergy	2	2.7	1	1.4
Duration (Length known person in years)				
1 to 2 years	0	.0	1	1.4
2 to 5 years	0	.0	1	1.4
5+ years	73	100.0	58	79.5
Geographic Proximity (Distance of person's home)				
Greater than 25 miles	22	30.1	33	45.2
Less than 25 miles	51	69.9	27	37.0
Person Visits				
Yes	70	95.9	54	74.0
No	3	4.1	6	8.2
Frequency of Visits				
Not at all	0	.0	4	5.5
A few times a year	8	11.0	11	15.1
1 to 2 times a month	19	26.0	18	24.7
1 to 3 times a week	30	41.1	25	34.2
About everyday	16	21.9	2	2.7

Table 6: *(continued)*

Variable	Person 1 (N = 73)		Person 2 (N = 60)	
	N	%	N	%
Pattern of Person's Visits				
Regular	22	30.1	14	19.2
Not regular	49	67.1	41	56.2
Don't know	2	2.7	1	1.4
Not applicable			4	5.5
Talk on the Phone				
Yes	55	75.3	44	60.3
No	18	24.7	16	21.9
Frequency of Phone Contact				
Not at all	16	21.9	13	17.8
A few times a year	1	1.4	4	5.5
1 to 2 times a month	10	13.7	18	24.7
1 to 3 times a week	37	50.7	23	31.5
About everyday	9	12.3	2	2.7
Pattern of Person's Phone Calls				
Regular	2	2.7	4	5.5
Not regular	55	75.3	44	60.3
Not Applicable	16	21.9	12	16.4
Send letters/cards with Person				
Yes	6	8.2	13	17.8
No	67	91.8	47	64.4
Frequency of Mail Contact				
Not at all	66	90.4	46	63.0
A few times a year	6	8.2	11	15.1
1 to 2 times a month	1	1.4	3	4.1
Pattern of Person's Letters/Cards				
Regular	1	1.4	3	4.1
Not regular	5	6.8	10	13.7
Not Applicable	67	91.8	47	64.4

Table 6: *(continued)*

Variable	Person 1 (N = 73)		Person 2 (N = 60)	
	N	%	N	%
Reciprocity (Give and take relationship)				
Don't know	6	8.2	17	23.3
You give more	1	1.4	0	.0
Person gives more	62	84.9	40	54.8
Both give equally	4	5.5	3	4.1
Perceived Adequacy (Support from person)				
Don't know	4	5.5	8	11.0
Less	5	6.8	9	12.3
More	29	39.7	4	5.5
About right	35	47.9	39	53.4
Perceived Satisfaction (Satisfaction with Overall Support)				
Satisfied	62	84.9	40	54.8
Dissatisfied	10	13.7	17	23.3
Don't know	1	1.4	3	4.1

Note. There will be 13 "missing" in each column representing the sample for person #2 because only 60 of the total sample reported a secondary support person.

Social Support Behaviors

Person 1

As shown in Table 7, slightly more than a third (37%, n = 27) of the respondents indicated that their primary source of support showed them physical affection and 42.5% reported that their primary person complimented them on a personal quality. However, the majority of the respondents: 98.6% reported that their primary source of support listened to them talk about their personal feelings; 91.8% gave them advice; 97.3% updated them on personal and/or current events; 83.6% made them feel accepted; and 95.9% managed their bank accounts. The respondents noted, however, that their primary source of support also made them feel sad (n = 68, 93.2%). A few (8.2%) indicated that their primary source of support made them feel upset.

Person 2

Twenty six percent of the respondents indicated that their secondary source of support showed them physical affection, 19.2% reported that their secondary source of support complimented them on a personal quality, and 38.4% reported that this person managed their bank accounts (Table 7). The majority of the respondents reported that their secondary source of support: listened to them talk about their personal feelings (n = 56, 76.7%); gave them advice (n = 41, 56.2%); updated them on personal and/or current events (n= 51, 69.9%); and made them feel accepted (n = 45, 61.6%). The respondents also noted, however, that their secondary source of support made them feel sad (n = 45, 61.6%) and upset (n = 7, 9.6%).

In summary, the forms of social support were varied, with more participants reporting being listened to when talking about their feelings, being updated on

personal/current events and being made to feel accepted. Interestingly, more respondents reported having their finances managed by their support persons than having errands or chores performed for them.

Table 7: Social Support Behaviors of the Study Participants

Variable	Person 1 (*N* = 73)		Person 2 (*N* = 60)	
	N	%	N	%
Affective				
Shown you physical affection	27	37.0	19	26.0
Listened to you talk about feelings	72	98.6	56	76.7
Informational				
Given you advice	67	91.8	41	56.2
Updated you on personal/current events	71	97.3	51	69.9
Appraisal				
Made you feel accepted	61	83.6	45	61.6
Complimented you on a personal quality	31	42.5	14	19.2
Instrumental				
Managed your bank account/paid bills	70	95.9	28	38.4
Does errands or chores for you	12	16.4	8	11.0
Negative				
Made you feel upset or distressed	6	8.2	7	9.6
Made you feel sad or hurt	68	93.2	45	61.6

Psychosocial Well-Being

Table 8 presents psychosocial well-being variables of the study participants as captured through health status data from the MDS. These variables are classified according to the sense of initiative/involvement, unsettled relationship, and past roles. As observed in Table 8, participants had established their own goals (*n* = 72, 98.6%), accepted invitations into most group activities (*n* = 62, 84.9%), were at ease doing self-initiative activities (*n* = 58, 79.5%), and interacting with others (*n* = 41, 56.2%). The highest number of initiatives was seven, with a mean of 3.89 (SD = 1.51), indicating that the respondents initiated a moderate amount of activities.

In terms of unsettled relationship/conflicts, only a few participants had open conflicts with staff (*n* = 8, 11.0 %) and were unhappy with residents other than their roommate (*n* = 6, 8.2%). The highest number of unsettled relationship/conflicts was seven, with a mean of 0.40 (SD = 0.80). Therefore, the respondents did experience significant conflicts. All the participants presented a strong identification with past roles and life status.

In summary, the majority of the participants were very active in the nursing home and had very strong identification with past roles and life status. Most experienced very few problems with organizational staff and other residents of the nursing home.

Table 8: Psychosocial Well-Being Variables of the Study Participants (N = 73)

Variable	N	%
Sense of Initiative/Involvement		
At ease interacting with others	41	56.2
At ease doing planned or structured activities	33	45.2
At ease doing self-initiative activities	58	79.5
Establish own goals	72	98.6
Pursues involvement in life of facility	17	23.3
Accepts invitations into most group activities	62	84.9
Unsettled Relationships		
Covert/open conflict with staff	8	11.0
Unhappy with roommate	1	1.4
Unhappy with residents other than roommate	6	8.2
Open conflict with family/friends	5	6.8
Absence of personal contact with family/friends	5	6.8
Recent loss of family/friend	2	2.7
Does not adjust easily to change in routines	2	2.7
Past Roles and Life Status		
Strong identification with past roles and life status	73	100.0
Expresses sadness/anger over lost roles/status	26	35.6
Resident perceives routine is different	1	1.4

Bivariate Analyses

Several bivariate analysis procedures were conducted to assess the relationships between the independent variables (i.e., demographics, health, social support, and psychosocial well-being) and the dependent variables (i.e., ADL impairments, mood/depressive symptoms, and self-rated health). Independent samples t-test and chi-square procedures were conducted for independent variables that consisted of two categories. One-way Analysis of Variance (ANOVA) procedures were conducted for independent variables that consisted of three or more categories. Spearman or Pearson correlations tests were conducted for independent variables that were measured using ordinal or interval/ratio scales, respectively.

The following variables were collapsed and recoded to fulfill the requirements for linearity, normality and homoscedasticity: age; education; length (number) of years in the current facility; occupation; and participant's religious affiliation. In addition, the responses for Person 1 and Person 2 were added together in order to capture the full range of support received. Each social support variable was recoded to identify the number of persons performing the specific social support function.

Correlates of ADL Impairments

Demographics and ADL Impairments

Independent samples t-test and one-way analysis of variance (ANOVA) procedures were conducted to test the relationship between the demographic variables and ADL impairments. The findings in Table 9 reveal that respondents' religion was

marginally related to ADL impairments, $F(2, 70) = 3.08$, $p = .052$. Christian/Protestant respondents had marginally higher ADL scores ($M = 2.66$, $SD = .80$) than Catholic respondents ($M = 2.13$, $SD = .56$) and Buddhist respondents ($M = 2.45$, $SD = .60$). Higher scores on the ADL measure indicated lower functioning, and the findings indicate that Catholic and Buddhist respondents fared better than their Protestant counterparts.

Table 9: Demographics and ADL Impairments (N = 73)

Demographic Variable	**Sig.**
Age[2]	.293
Gender[1]	.287
Marital status[2]	.236
Level of education[2]	.520
Occupation[1]	.969
Religion[2]	.052
Number of years in current facility[2]	.531

[1] Independent samples t-test was conducted.
[2] One-way ANOVA was conducted.

Health and ADL Impairments

Spearman's rho correlation procedures were conducted to test the relationship between the health measures and ADL impairments. The findings in Table 10 reveal that the total number of diseases ($r = .31$, $p = .008$) and mean continence scores ($r = .77$, $p = .001$) were significantly associated with ADL impairment scores. Thus, those in poorer health had higher ADL impairment scores.

Table 10: Spearman's rho Results between the Health and ADL Impairments (N = 73)

Health Variable	**Sig.**
Total number of diseases (Section I. Q# 14, Appendix E)	.008
Total number of cognitive deficits (Section B. Q# 5, 6, Appendix E)	.147
Mean continence (Section H. Q#13a, 13b, Appendix E)	.001

Social Support and ADL Impairments

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of social support and ADL impairments. The findings in Table 11 reveal that *appraisal* support behaviors were significantly associated with ADL impairments (r = -.34, p = .004). Thus, the more sources of support made the respondents feel accepted or complimented the respondents, the lower were their ADL impairment scores.

Table 11: Social Support and ADL Impairments (N = 73)

Social Support Variable	**Sig.**
Number of support persons[1]	.641
Distance of home of support persons[1]	.862
Nuclear vs. non-nuclear family member[2]	.786
Frequency of support[2]	.349
Affective support[2]	.944
Informational support[2]	.465
Appraisal support[2]	.004
Instrumental support[2]	.903
Negative emotions[2]	.942
Perceptions of giving[2]	.462
Perceptions of support[2]	.540
Satisfaction with support person[2]	.320

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

Psychosocial Well-Being and ADL Impairments

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of psychosocial well-being and ADL impairments. The findings in Table 12 reveal that number of activities (r = -.49, p = .001) and number of initiatives (r = -.56, p = .001) were significantly correlated with ADL impairment scores. Thus, the more activities and initiatives the respondents

participated in or made, the lower were their ADL impairment scores. Focus on past roles, however, was positively associated (r = .37, p = .001) with ADL impairment scores; the more respondents focused on their past roles, the higher were their ADL impairment scores.

Perceptions of control was also significantly related to ADL impairments, $t(71)$ = -2.11, p = .039. Respondents who believed they did not have enough control (or who were unsure about their control) had significantly higher ADL scores (M = 2.74, SD = .68) than respondents who believed they had enough control (M = 2.37, SD = .71). Lastly, having a private phone line in the room was significantly related to ADL impairments, $t(71)$ = -2.12, p = .038. Respondents without a phone in their room had significantly higher ADL scores (M = 2.80, SD = .66) than respondents who had a phone in their room (M = 2.39, SD = .71).

Table 12: Psychosocial Well-Being and ADL Impairments (N = 73)

Psychosocial Well-Being Variable	Sig.
Number of activities[2] (Section N. Q# 19, Appendix E)	.001
Focus on past roles[2] (Section F. Q# 11, Appendix E)	.001
Number of routines[2] (Section AC. Q# 32, Appendix E)	.624
Number of initiatives[2] (Section F. Q# 9, Appendix E)	.001
Perceptions of control[1] (SSQ# 62)	.039
Own telephone in room[1] (SSQ# 9)	.038
Change experience[1] (SSQ# 4 to # 8)	.912

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

In summary, Korean American nursing home residents in this study with lower ADL impairment were more likely to be Buddhist and Catholic, were active in the nursing home and were engaged in numerous initiatives, perceived themselves to be in control, had their own telephone in the room, and obtained positive appraisal from their

family. Ill-health and focusing on past roles were negative risk factors for ADL impairments.

Correlates of Depressive Symptomatology

Demographics and Depressive Symptoms

Independent samples t-test and one-way analysis of variance (ANOVA) procedures were conducted to test the relationship between the demographic variables and depression scores. The findings in Table 13 reveal that none of the demographic variables were significantly associated with depression scores. The length of stay in the current facility was marginally related to depression scores, $F(2, 70) = 2.45$, $p = .093$, and indicates that respondents with more years in the current facility had higher depression scores.

Table 13: Demographics and Depressive Symptoms (N = 73)

Demographic Variable	Sig.
Age[2]	.734
Gender[1]	.958
Marital status[2]	.152
Level of education[2]	.485
Occupation[1]	.661
Religion[2]	.494
Number of years in current facility[2]	.093

[1] Independent samples t-test was conducted.
[2] One-way ANOVA was conducted.

Health and Depressive Symptoms

Spearman's rho correlation procedures were conducted to test the relationship between the health measures and depression scores. The findings in Table 14 reveal that

the total number of diseases (r = .40, p = .001) and mean continence scores (r = .30, p = .009) were significantly associated with depression scores. Thus, the more diseases and the more incontinent the respondents were, the higher were their depression scores.

Table 14: Spearman's rho Results between the Health and Depressive Symptoms (N = 73)

Health Variable	**Sig.**
Total number of diseases (Section I. Q# 14, Appendix E)	.001
Total number of cognitive deficits (Section B. Q# 5, 6, Appendix E)	.115
Mean continence (Section H. Q# 13a, 13b, Appendix E)	.009

Social Support and Depressive Symptoms

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of social support and depression scores. The findings in Table 15 reveal that *appraisal* support behaviors (r = -.30, p = .009) and *satisfaction with support person* (r = -.27, p = .019) were negatively associated with depression scores but *instrumental* support behaviors were positively associated with depression scores (r = .31, p = .008). Thus, when the sources of support made the respondents feel accepted or when respondents felt supported by people they were close to, the lower their depression scores were. However, when the sources of support just managed bank accounts or did errands for the respondents (instrumental support behaviors), the higher their depression scores were.

Table 15: Social Support and Depressive Symptoms (N = 73)

Social Support Variable	Sig.
Number of support persons[1]	.135
Distance of home of support persons[1]	.565
Nuclear vs. non-nuclear family member[2]	.188
Frequency of support[2]	.917
Affective support[2]	.952
Informational support[2]	.902
Appraisal support[2]	.009
Instrumental support[2]	.008
Negative emotions[2]	.976
Perceptions of giving[2]	.107
Perceptions of support[2]	.246
Satisfaction with support person[2]	.019

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

Psychosocial Well-Being and Depressive Symptoms

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of psychosocial well-being and depression scores. The findings in Table 16 reveal that number of activities (r = -.52, p = .001) and number of initiatives (r = -.61, p = .001) were significantly correlated with depression scores. Thus, the more activities and initiatives the respondents participated in or made, the lower were their depression scores. Focus on past roles, however, was positively associated (r = .60, p = .001) with depression scores; the more respondents focused on their past roles, the higher were their depression scores. Perceptions of control was also significantly related to depression scores, $t(71) = -4.25$, p = .001. Respondents who believed they did not have enough control (or who were unsure about their control) had significantly higher depression scores (M = 7.17, SD = 2.44) than respondents who believed they had enough control (M = 3.44, SD = 3.87).

Table 16: Psychosocial Well-Being and Depressive Symptoms (N = 73)

Psychosocial Well-Being Variable	Sig.
Number of activities[2] (Section N. Q# 19, Appendix E)	.001
Focus on past roles[2] (Section F. Q# 11, Appendix E)	.001
Number of routines[2] (Section AC. Q# 32, Appendix E)	.488
Number of initiatives[2] (Section F. Q# 9, Appendix E)	.001
Perceptions of control[1] (SSQ# 62)	.001
Own telephone in room[1] (SSQ# 9)	.456
Change experience[1] (SSQ# 4 to 8)	.821

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

In summary, Korean American nursing home residents who were active in the nursing home and were engaged in numerous initiatives, perceived themselves to be in control, and obtained positive appraisal from their family were more likely to have lower depression scores. Focusing on past roles was a negative risk factor for depressive symptomatology as well.

Correlates of Self-rated Health

Demographics and Self-rated Health

Independent samples t-test and one-way analysis of variance (ANOVA) procedures were conducted to test the relationship between the demographic variables and self-rated health. The findings in Table 17 reveal that age was significantly related to health scores, $F(2, 70) = 3.21$, $p = .046$.

Respondents' religion was also significantly related to health scores, $F(2, 70) = 4.06$, $p = .021$. Post-hoc Tukey procedures indicated that Protestant respondents had significantly lower health scores ($M = 1.85$, $SD = .71$) than Catholic respondents ($M =$

2.39, *SD* = .61; *p* = .019). However, Protestant and Catholic respondents did not have significantly different scores from Buddhist respondents (*M* = 2.00, *SD* = .58).

Table 17: Demographics and Self-rated Health (N = 73)

Demographic Variable	**Sig.**
Age[2]	.046
Gender[1]	.999
Marital status[2]	.736
Level of education[2]	.722
Occupation[1]	.508
Religion[2]	.021
Number of years in current facility[2]	.793

[1] Independent samples t-test was conducted.
[2] One-way ANOVA was conducted.

Health and Self-rated Health

Spearman's rho correlation procedures were conducted to test the relationship between the health measures and self-rated health. The findings in Table 18 reveal that the total number of diseases (*r* = -.32, *p* = .006), number of cognitive deficits (*r* = -.25, *p* = .034), and mean continence scores (*r* = -.37, *p* = .001) were significantly associated with self-rated health scores. Thus, the more diseases, the more cognitive deficits, and the more incontinent the respondents were, the lower were their self-rated health scores.

Table 18: Spearman's rho Results between the Health and Self-rated Health (N = 73)

Health Variable	**Sig.**
Total number of diseases (Section I. Q# 14, Appendix E)	.006
Total number of cognitive deficits (Section B. Q# 5, 6, Appendix E)	.034
Mean continence (Section H. Q# 13a, 13b, Appendix E)	.001

Social Support and Self-rated Health

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of social support and self-rated health. The findings in Table 19 reveal that *appraisal* support behaviors ($r = .40$, $p = .001$), *perceptions of giving* ($r = .27$, $p = .021$), and *satisfaction with support person* ($r = .27$, $p = .020$) were positively associated with self-rated health scores. Thus, when the sources of support made the respondents feel accepted, when respondents perceived the other persons to be more giving, and when the respondents were satisfied with the support they received from people close to them, their self-rated health scores were higher.

Table 19: Social Support and Self-rated Health (N = 73)

Social Support Variable	**Sig.**
Number of support persons[1]	.391
Distance of home of support persons[1]	.105
Nuclear vs. non-nuclear family member[2]	.472
Frequency of support[2]	.694
Affective support[2]	.572
Informational support[2]	.474
Appraisal support[2]	.001
Instrumental support[2]	.199
Negative emotions[2]	.083
Perceptions of giving[2]	.021
Perceptions of support[2]	.068
Satisfaction with support person[2]	.020

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

Psychosocial Well-Being and Self-rated Health

Independent samples t-test and Pearson correlation procedures were conducted to determine the relationship between the various measures of psychosocial well-being and

self-rated health. The findings in Table 20 reveal that number of activities (r = .40, p = .001) and number of initiatives (r = .55, p = .001) were significantly correlated with self-rated health scores. Thus, the more activities and initiatives the respondents participated in or made, the higher were their self-rated health scores. Focus on past roles, however, was again negatively associated (r = -.50, p = .001) with self-rated health scores; the more respondents focused on their past roles, the lower were their self-rated health scores. Perceptions of control was also significantly related to self-rated health scores, $t(71) = 6.83$, p = .001. Respondents who believed they did not have enough control (or who were unsure about their control) had significantly lower self-rated health scores (M = 1.35, SD = .49) than respondents who believed they had enough control (M = 2.30, SD = .58). Lastly, having a private phone line in the room was significantly related to self-related health scores, $t(71) = 2.00$, p = .050. Respondents without a phone in their room had significantly lower self-rated health scores (M = 1.71, SD = .69) than respondents who had a phone in their room (M = 2.09, SD = .70).

Table 20: Psychosocial Well-Being and Self-rated Health (N = 73)

Psychosocial Well-Being Variable	**Sig.**
Number of activities[2] (Section N. Q# 19, Appendix E)	.001
Focus on past roles[2] (Section F. Q#11, Appendix E)	.001
Number of routines[2] (Section AC. Q# 32, Appendix E)	.671
Number of initiatives[2] (Section F. Q# 9, Appendix E)	.001
Perceptions of control[1] (SSQ# 62)	.001
Own telephone in room[1] (SSQ# 9)	.050
Change experience[1] (SSQ# 4 to 8)	.489

[1] Independent samples t-test was conducted.
[2] Pearson correlation procedure was conducted.

In summary, Korean American nursing home residents who were Catholic, obtained positive appraisal from their family, perceived themselves as having family support and those who were satisfied with the support they received were more likely to rate their health more positively. In addition, those who were active in the nursing home and were engaged in numerous initiatives, and had their own telephone in their room were more likely to have higher self-rated health scores. Focusing on past roles and perceptions of no control were negative risk factor for self-rated health.

Overall, the pattern in the direction of the relationships between the independent variables and all the dependent variables (ADL impairments, depressive symptoms and self-rated health) is similar. Korean American nursing home residents who were active in the nursing home and were engaged in numerous initiatives, had their own telephone in their room, perceived themselves to be in control, and obtained positive appraisal from their family were more likely to have higher ADL functioning and self-rated health scores, and lower depression scores. Focusing on past roles was a negative risk factor for ADL impairment, depressive symptomatology and self-rated health.

Multivariate Analysis

Procedure for Testing the First Three Hypotheses

Prior to conducting the regression analyses, data were evaluated to diagnose whether multicollinearity existed among predictor variables to be used in the regression models. Multicollinearity severely limits the size of maximized correlation (R) between

the predictor variables and the criterion variable, it leads to overlapping information from predictor variables and results in an unstable prediction equation. The goal therefore, of any multiple regression analysis is orthogonality (independence) among predictor variables or low collinearity between predictor variables. Collinearity among this study's variables was evaluated through the use of ***Tolerance*** statistics, which provides tolerance values (ranging between 0 and 1, with .1 being the cutoff point). Any values below .1 indicate a distinct problem of multicollinearity and values above .1 and closer to one indicate orthogonality among variables (the desired goal).

Covariate Model

Theoretically interesting demographic variables, such as age and religion, were included as control variables in all regression models. Other demographic and psychosocial well-being variables that were significantly related to the three outcome measures in the bivariate analyses were also included as control variables.

None of the control variables had tolerance values below .1, however, *number of activities* and *number of initiatives* had tolerance values of .29 and .39, respectively (Appendix A), with a Pearson correlation of .72 between the two variables. Sprinthall (2000) suggests the deletion of covariates with intercorrelations of .80 or above, and since *number of initiatives* had the higher partial correlation across the three regression models, only this variable was retained in the covariate model. The tolerance values for the covariates in the final model were all above .40.

Social Support Model

All social support variables were also initially included in the regression model. But the tolerance values of several social support predictors were very low (Appendix B). First, the variables *size of network*, *strength of network*, and *frequency of support* variables were highly correlated with each other (i.e., Pearson correlations were between .71 and .90). The variable, *network size* had the highest partial correlation across the three regression models, and was therefore, the only variable retained. Second, the correlation between the variables *affective, informational, giving, support*, and *satisfaction* were also highly correlated with each other (i.e., Pearson correlations ranged from .65 to .79). The variable, *subjective measure of giving* had the highest partial correlation across the three regression models, and consequently, only this variable was retained. The tolerance values for the social support variables in the final model were therefore, all above .42.

Hypotheses Tests

The two ***multiple linear regression*** procedures outlined above were then conducted. First, a *stepwise* procedure was conducted with all the covariates and social support variables (regardless of tolerance since the stepwise procedure automatically eliminates variables with low tolerance values). The criterion for entry was the SPSS default of .05; the criterion for removal was the SPSS default of .10. Second, a *hierarchical forced entry* procedure was done. For each procedure, the first step included the entry of the control variables into the model; in the second step, the social support variables were entered into the model.

Finally, a ***multivariate analysis of covariance (MANCOVA)*** was then conducted. Only the predictors that significantly predicted the three outcome measures were included in the MANCOVA procedure.

Social Support and *ADL Impairments*

It was hypothesized that, after controlling for demographics, health, and psychosocial well-being, social support would significantly predict ADL impairments. Stepwise and hierarchical linear regression procedures were conducted to test this hypothesis.

Stepwise Linear Regression Findings

The findings in Table 21 reveal that none of the social support variables significantly predicted ADL impairments. Only *continence* ($\beta = .60$, $p < .001$) and *total number of initiatives* ($\beta = -.32$, $p < .001$) significantly predicted ADL impairments. Higher scores indicated incontinence and lower scores indicated continence. Thus, the more incontinent the respondents were and the fewer initiatives they participated in, the higher were their ADL impairments.

Table 21: Stepwise Linear Regression Results for ADL Impairments (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Mean continence	.32	.60	7.39	.000	.73	.66
Number of initiatives	-.15	-.32	-3.90	.000	-.56	-.42

Note. Only the findings of the second step are summarized. Model $F(2, 70) = 54.94$, $p < .001$. Model $R^2 = .611$. Model adjusted $R^2 = .600$.

Hierarchical Linear Regression Findings

The findings in Table 22 reveal that after controlling for demographics, health, and psychosocial well-being, none of the social support variables significantly predicted ADL impairments. Only *continence* significantly predicted ADL impairment scores (β = .55, $p < .001$). Thus, the more incontinent the respondents were, the higher were their ADL impairment scores.

Table 22: Hierarchical Linear Regression Results for ADL Impairments (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Age	-.01	-.13	-1.43	.159	-.28	-.19
Religion	.28	.12	1.37	.175	.05	.18
Years in current facility	-.01	-.07	-.86	.394	-.15	-.11
Number of diseases	.02	.10	.97	.338	.29	.13
Mean continence	.29	.55	5.86	.000	.73	.61
Focus on past roles	.04	.03	.24	.812	.37	.03
Number of initiatives	-.09	-.20	-1.52	.134	-.56	-.20
Telephone in room	.21	.12	1.27	.209	.24	.17
Size	.10	.06	.40	.693	.06	.05
Distance	-.08	-.05	-.53	.602	-.08	-.07
Appraisal support	-.04	-.07	-.60	.553	-.34	-.08
Instrumental support	-.05	-.06	-.61	.524	.01	-.09
Negative emotions/behaviors	.03	.03	.23	.819	.01	.03
Perceptions of giving	.02	.05	.44	.664	-.09	.06
Perceptions of control	-.11	-.08	-.64	.524	-.24	-.09

Note. Only the findings of the second step are summarized. Model $F(15, 57) = 7.65$, $p < .001$. Model $R^2 = .668$. Model adjusted $R^2 = .581$.

Summary

It was hypothesized that, after controlling for demographics, health, and psychosocial well-being, social support would significantly predict ADL impairments. Both the stepwise and hierarchical linear regression findings however, did not support this hypothesis.

Social Support and *Depressive Symptoms*

It was hypothesized that, after controlling for demographics, health, and psychosocial well-being, social support would significantly predict depressive symptoms. Stepwise and hierarchical linear regression procedures were used to test this hypothesis.

Stepwise Linear Regression Findings

The findings in Table 23 reveal that, after controlling for demographics, health, and psychosocial well-being, *perceptions of control* (a social support variable) significantly predicted depressive symptoms (β = -.39, p = .001). Respondents who believed they did not have enough control had significantly higher depression scores (M = 7.17, SD = 2.44) than respondents who believed they had enough control (M = 3.08, SD = 2.79; p = .001). Three control variables also significantly predicted depressive symptoms: *number of initiatives* (β = -.50, p = .001); *religion* (β = .18, p = .030); and *age* (β = .16, p = .046). The fewer initiatives respondents participated in and the older the respondents, the higher were their depressive symptoms. Christian or Catholic respondents had significantly higher depressive symptoms (M = 4.50, SD = 3.29) than respondents who did not have any religion or were Buddhist (M = 3.14, SD = 3.24).

Table 23: Stepwise Linear Regression Results for Depressive Symptoms (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Number of initiatives	-1.09	-.50	-5.66	.000	-.63	-.57
Perceptions of control	-2.72	-.39	-4.43	.000	-.58	-.47
Religion	1.95	.18	2.21	.030	.12	.26
Age	.07	.16	2.03	.046	.09	.24

Note. Only the results of the fourth step are summarized. Model $F(4, 68) = 23.06$, $p < .001$. Model $R^2 = .576$. Model adjusted $R^2 = .551$.

Hierarchical Linear Regression Findings

The findings in Table 24 reveal that after controlling for demographics, health, and psychosocial well-being, the social support variable, *perceptions of control* significantly predicted depressive symptoms (β = -.31, p = .008). Respondents who *believed they did not have enough control* had significantly higher depressive symptoms (M = 7.17, SD = 2.44) than respondents who believed they had enough control (M = 3.08, SD = 2.79; p = .001). Two control variables significantly predicted depressive symptoms. *Focus on past roles* (β = .30, p = .007) and *age* (β = .21, p = .017) significantly predicted depressive symptoms. The more respondents focused on their past roles and the older the respondents, the higher were their depressive symptoms.

Table 24: Hierarchical Linear Regression Results for Depressive Symptoms (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Age	.09	.21	2.46	.017	.09	.31
Religion	1.59	.14	1.78	.080	.12	.23
Years in current facility	.12	.13	1.64	.106	.09	.21
Number of diseases	.01	.01	.14	.887	.40	.02
Mean incontinence	.40	.17	1.87	.067	.28	.24
Focus on past roles	1.94	.30	2.79	.007	.62	.35
Number of initiatives	-.45	-.21	-1.69	.097	-.63	-.22
Telephone in room	-.83	-.11	-1.15	.254	.15	-.15
Size	1.73	.20	1.51	.137	.17	.20
Distance	-.72	-.11	-1.12	.266	.05	-.15
Appraisal support	-.38	-.14	-1.22	.227	-.42	-.16
Instrumental support	.24	.06	.66	.510	.23	.09
Negative emotions/behaviors	-.97	-.20	-1.88	.066	-.04	-.24
Perceptions of giving	-.05	-.03	-.26	.795	-.23	-.04
Perceptions of control	-2.15	-.31	-2.76	.008	-.58	-.34

Note. Only the findings of the second step are summarized. Model $F(15, 57) = 8.69$, $p < .001$. Model $R^2 = .696$. Model adjusted $R^2 = .616$.

Summary

It was hypothesized that, after controlling for demographics, health, and psychosocial well-being, social support would significantly predict depressive symptoms. Both the hierarchical and stepwise linear regression findings provide support for this hypothesis with regard to one of the variables for social support: *perceptions of control* significantly predicted depressive symptoms.

Social Support and *Self-rated Health*

It was hypothesized that, after controlling for demographics, health, and psychosocial well-being, social support would significantly predict self-rated health. Stepwise and hierarchical linear regression procedures were conducted to test this hypothesis.

Stepwise Linear Regression Findings

The findings in Table 25 reveal that, after controlling for demographics, health, and psychosocial well-being, two social support variables (*perceptions of control* and *negative emotions/behaviors*) significantly predicted self-rated health. First, respondents who believed they did not have enough control had significantly lower health ratings (M = 1.35, SD = .49) than respondents who believed they had enough control (M = 2.30, SD = .58), (β = .49, p = .000). Second, negative emotions/behaviors exhibited by support persons positively predicted self-rated health (β = .21, p = .014). Contrary to expectations, persons who had higher self-rated health scores also reported more negative behaviors exhibited by the support persons in their lives.

Three control variables also significantly predicted self-rated health. *Continence* (β = -.26, p = .005), *number of initiatives* (β = .27, p = .006), and *age* (β = -.18, p = .038) significantly predicted self-rated health. As indicated before, higher scores indicate incontinence and lower scores indicate continence. Therefore, respondents with higher incontinence scores were more likely to have lower self-rated health scores. Older respondents were also more likely to have lower self-rated health scores. However, respondents engaged in a number of initiatives were more likely to have higher self-rated health scores.

Table 25: Stepwise Linear Regression Results for Self-rated Health (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Perceptions of control	.74	.49	5.57	.000	.63	.56
Mean continence	-.13	-.26	-2.92	.005	-.35	-.34
Number of initiatives	.13	.27	2.83	.006	.55	.33
Negative emotions/behaviors	.22	.21	2.54	.014	.21	.30
Age	-.02	-.18	-2.12	.038	-.02	-.25

Note. Only the findings of the fifth step are summarized. Model $F(5, 67) = 19.26$, $p < .001$. Model $R^2 = .590$. Model adjusted $R^2 = .559$.

Hierarchical Linear Regression Findings

The findings in Table 26 reveal that after controlling for demographics, health, and psychosocial well-being, two social support variables (*perceptions of control* and *negative emotions/behaviors*) significantly predicted self-rated health. First, respondents who believed they did not have enough control had significantly lower self-rated health (M = 1.35, SD = .49) than respondents who believed they had enough control (M = 2.30, SD = .58; β = .48, $p < .001$). Second, negative emotions/behaviors positively predicted self-rated health (β = .31, p = .010). Contrary to expectations, the more negative

emotions/behaviors the support persons exhibited towards the respondent, the higher was their self-rated health. One control variable, *continence* (β = -.26, p = .010), significantly predicted self-rated health. Respondents with higher continence scores (indicating incontinence) were more likely to have lower self-rated health scores.

Table 26: Hierarchical Linear Regression Results for Self-rated Health (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Age	-.02	-.18	-1.93	.059	-.02	-.25
Religion	-.16	-.07	-.74	.464	.00	-.10
Years in current facility	-.00	-.01	-.11	.916	.07	-.01
Number of diseases	.00	.01	.05	.963	-.33	.01
Mean continence	-.14	-.26	-2.67	.010	-.35	-.33
Focus on past roles	-.27	-.20	-1.66	.103	-.50	-.21
Number of initiatives	.07	.14	1.03	.307	.55	.14
Telephone in room	.03	.02	.17	.866	-.23	.02
Size	-.23	-.12	-.84	.403	-.10	-.11
Distance	.16	.11	1.03	.308	-.08	.14
Appraisal support	.01	.01	.12	.908	.40	.02
Instrumental support	-.01	-.01	-.06	.957	-.15	-.01
Negative emotions/behaviors	.33	.31	2.68	.010	.21	.34
Perceptions of giving	-.01	-.03	-.21	.837	.27	-.03
Perceptions of control	.73	.48	3.93	.000	.63	.46

Note. Only the findings of the second step are summarized. Model $F(15, 57) = 6.53$, $p < .001$. Model $R^2 = .632$. Model adjusted $R^2 = .535$.

Summary

It was hypothesized that, after controlling for demographics, health, and psychosocial wellbeing, social support would significantly predict overall health. Both the hierarchical and stepwise findings provide support for this hypothesis with regard to *perceptions of control* and *negative emotions/behaviors*. Both significantly predicted self-rated health.

Social Support, ADL Impairments, Depressive Symptoms, and Self-rated Health

A multivariate analysis of covariance procedure (MANCOVA) was conducted to determine whether social support would significantly predict ADL impairments, depressive symptoms, and self-rated health, after controlling for demographics, health, and psychosocial well-being. The findings in Table 27 reveal that *perceptions of control* significantly predicted ADL impairments, depressive symptoms, and self-rated health $F(3, 63) = 11.30$, $p < .001$ and accounts for 35% of variance in ADL impairments, depressive symptoms and self-rated health.

Table 27: MANCOVA Results for Social Support, ADL Impairments, Depressive Symptoms, and Self-rated Health (N = 73)

Variable	*Wilks'* λ	F	Sig.	Partial η^2
Age	.84	3.96	.012	.16
Religion	.93	1.64	.189	.04
Mean continence	.55	17.04	.000	.45
Number of initiatives	.86	3.33	.025	.14
Focus on past roles	.89	2.57	.062	.11
Negative emotions/behaviors	.87	3.09	.033	.13
Perceptions of control	.65	11.30	.000	.35

The Interactive Effects: Social Support Variables and ADL Impairments, Depressive Symptoms, and Self-rated Health

The final hypothesis for this study posited that *frequency of interactions/visits* with support persons, *negative behaviors, subjective perceptions (giving, support*, and *satisfaction)*, and *perceptions of control* would predict ADL impairments, depression scores, and overall health ratings. The purpose of this hypothesis was to test for moderating or interaction effects among these variables.

Procedure

Prior to conducting the linear regression procedures, the tolerance values of the predictors were examined. Subjective perceptions and frequency of interactions/visits had low tolerance values (i.e., values ranged from .27 to .39). Indeed, Pearson correlations between these variables ranged from .64 to .71. Because frequency of interactions/visits had the highest partial correlation across the three procedures, it was retained in the model; the subjective perceptions were excluded from subsequent interaction effect procedures. Tolerance values for the remaining three predictors ranged from .85 to .86 (tolerance increased when the subjective perceptions were excluded) indicating an absence of multicollinearity.

Three hierarchical linear regression procedures were then conducted. The predictors were entered in the first step and the product terms were entered in the second step. Because product terms were the primary units of analyses and because product terms are highly related to their main effects terms, all predictors were transformed into mean deviation form prior to conducting the linear regression procedures. Tolerance values were good and ranged from .63 to .90.

ADL Impairments

The findings in Table 28 indicate that the interactive or moderating effects of *frequency of interactions/visits, negative behaviors*, and *perceptions of control* did not significantly predict ADL impairments. In other words, there is no support for the hypothesis which posits that the above-mentioned variables moderate the relationship

between social support and ADL impairments. Social support is thus independent and additive, not interactive, in its relation to ADL impairments.

None of the main effects significantly predicted ADL impairments. *Perceptions of control*, however, approached statistical significance ($p = .087$). Type II error (being unable to reject a true null hypothesis), as is probably the case here, can be avoided in the future with a larger sample. This variable's main effect on ADL impairment may then be statistically significant.

Table 28: Hierarchical Linear Regression Results for Interactive Social Support Variables and ADL Impairments (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Frequency	-.03	-.15	-1.01	.314	-.11	-.12
Negative emotions/behaviors	.09	.09	.64	.523	.01	.08
Perceptions of control	-.33	-.21	-1.74	.087	-.24	-.21
Frequency x negativity	-.04	-.13	-.96	.340	-.11	-.12
Frequency x control	.00	.01	.06	.957	.03	.01
Negativity x control	-.29	-.12	-.97	.338	-.11	-.12

Note. Only the findings of the second step are summarized. Model $F(6, 66) = 1.19$, $p = .323$. Model $R^2 = .098$. Model adjusted $R^2 = .016$.

Depressive Symptoms

The findings in Table 29 indicate that *negative behaviors* moderated the effect of *frequency of interactions/visits* on depression ($\beta = -.29$, $p = .009$). As shown in Figure 3, for respondents whose support persons did not exhibit much negative behavior, frequency of interaction/visits had a minimal effect on depressive symptoms. But for respondents whose support persons exhibited more negative behavior, frequency of interactions/visits had a stronger effect on depressive symptoms; the more frequently the support person visited or interacted with the respondent, the lower was their depressive score.

Negative behaviors also moderated the effect of *perceptions of control* on depressive symptoms (β = -.21, p = .043). The interaction depicted in Figure 4 reveals that for respondents whose support persons did not exhibit much negative behavior, perceptions of control did not have much of an effect on depressive scores. But for respondents whose support persons exhibited more negative behavior, perceptions of control had an effect on depressive scores; those who believed they had enough control, had lower depressive scores than those who felt they did not have enough control.

Table 29: Hierarchical Linear Regression Results for Interactive Social Support Variables and Depressive Symptoms (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Frequency	-.08	-.10	-.84	.407	-.05	-.10
Negative behaviors	.23	.05	.43	.670	-.04	.05
Perceptions of control	-3.61	-.51	-5.26	.000	-.58	-.54
Frequency x negativity	-.36	-.29	-2.69	.009	-.35	-.31
Frequency x control	.05	.03	.28	.783	.04	.03
Negativity x control	-2.22	-.21	-2.06	.043	-.13	-.25

Note. Only the findings of the second step are summarized. Model $F(6, 66) = 8.39$, p = .001. Model R^2 = .433. Model adjusted R^2 = .381.

Figure 3: Negative Behaviors as a Moderator of the Effect of Frequency on Depressive Symptoms

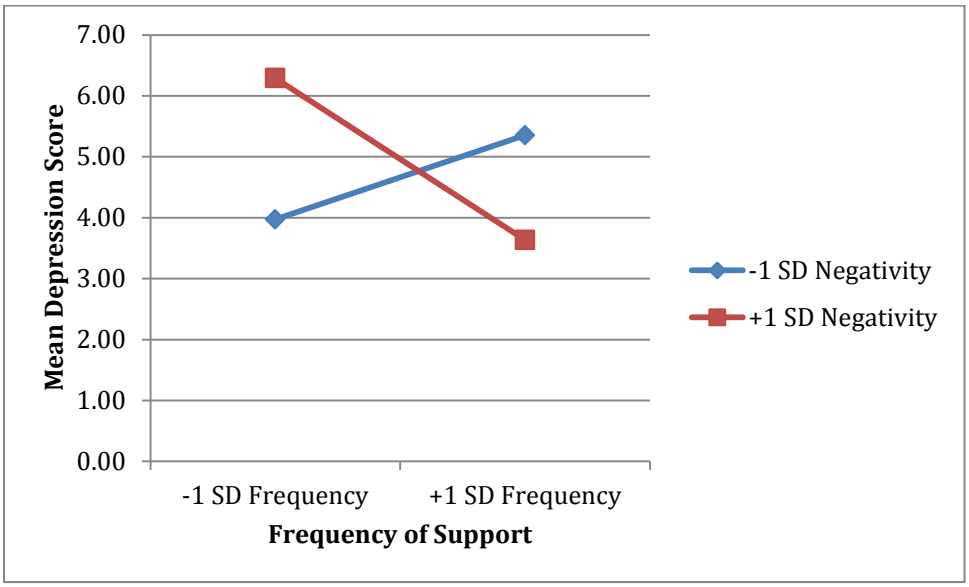
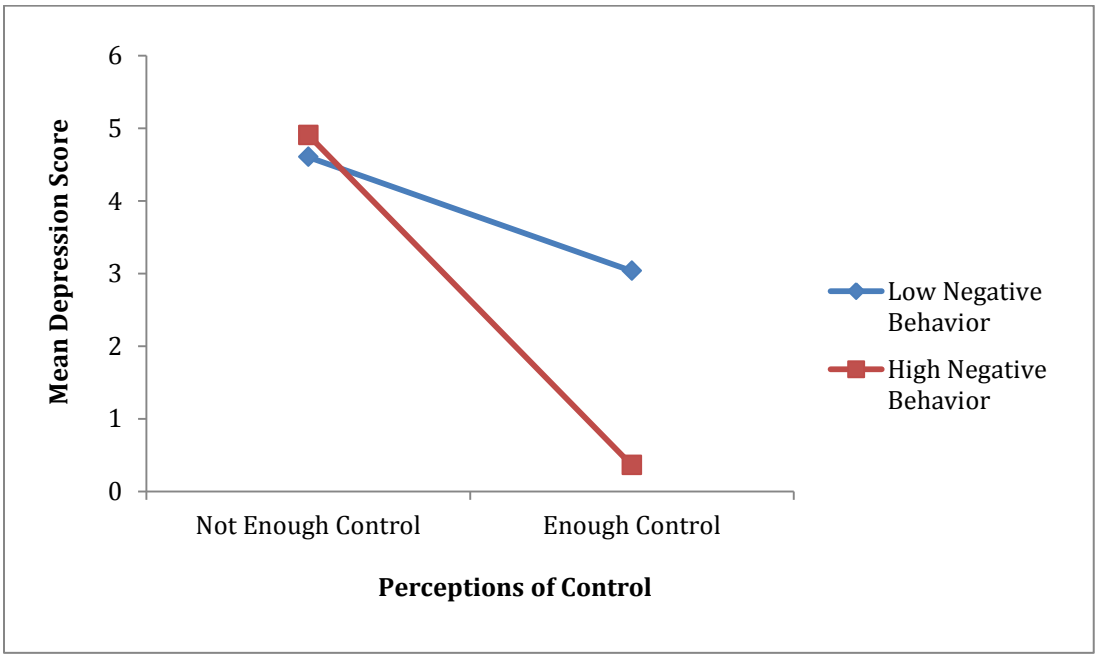


Figure 4: Negative Behaviors as a Moderator of the Effect of Perceptions of Control on Depressive Symptoms



Self-rated Health

The findings in Table 30 indicate that the interactive effects of frequency, negative behaviors, and perceptions of control did not significantly predict self-rated health. Only *perceived control* significantly predicted self-rated health (β = .59, $p < .001$).

Table 30: Hierarchical Linear Regression Results for Interactive Social Support Variables and Self-rated Health (N = 73)

Variable	B	β	*t*	Sig.	Zero Order *r*	Partial *r*
Frequency	-.01	-.04	-.31	.759	.05	-.04
Negative emotions/behaviors	.18	.17	1.63	.107	.21	.20
Perceptions of control	.89	.59	6.14	.000	.63	.60
Frequency x negativity	.04	.14	1.34	.184	.28	.16
Frequency x control	-.01	-.04	-.35	.726	.02	-.04
Negativity x control	.36	.16	1.60	.114	.09	.19

Note. Only the findings of the second step are summarized. Model $F(6, 66) = 9.24$, $p = .001$. Model $R^2 = .457$. Model adjusted $R^2 = .407$.

Summary

It was hypothesized that frequency of interactions with support persons, negative behaviors, subjective perceptions of giving, support, and satisfaction, and perceptions of control would predict ADL impairments, depressive symptoms, and self-rated health. The hypothesis was partially supported; *negative behaviors* moderated the effects of frequency of interactions/visits and perceptions of control on depressive symptoms.

CHAPTER VI. DISCUSSION AND IMPLICATIONS

The present study examined the relationship between social support and health-related quality of life among Korean American nursing home residents. It was the first empirical study to examine these issues among Korean American nursing home residents in New York City. The major aims of this exploratory, mixed-method study were twofold. First, the study examined the social support networks of the Korean American nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators. Second, the study identified and addressed those features of social support that have the greatest potential for facilitating Korean American residents' quality of life.

Social support was operationalized as social network, social support functions/contents, negative social interactions, directions of support, and subjective measures of the support transactions. Health status was operationalized as three quality of life indicators: ADL impairments; depressive symptoms; and self-rated health.

The findings of this study showed that social support, and more importantly *perceptions of support,* is an important component in the lives of Korean American nursing home residents. Participants in this study identified one or two of the most important persons in their life to represent their social support networks. All of the participants (100%) in the sample had at least one important person in their life and 60 participants were able to identify another important person in his/her life. Their important source of social support was immediate family members (adult children).

This finding is consistent with previous studies (Han et al., 2007), reporting that adult children were found to be the most common source of support, regardless of the type of need. The proximity of these adult children was also an important factor in the lives of the respondents. Almost two thirds of the respondents (61.6%) had at least one important support person residing within 25 miles of the nursing home.

Residents nurtured their social connections through frequent and ongoing visits or phone contacts by their support persons. Almost all study participants (95.9%) reported that they were visited in the nursing home by their support persons. About twenty six percent of the participants received monthly visitation from their support persons, while almost three-fourths (73%) received at least weekly visitation. In addition, 63% of the respondents reported at least weekly phone contact, while 13.7% reported monthly phone contacts at the minimum.

The respondents reported supportive and positive experiences with their source of support person. The forms of social support were varied, and included being: listened to when talking about their feelings (98.6%); given advice (91.8%); updated on personal/current events (97.3%); made to feel accepted (83.6%); and having their finances managed by their support persons (95.9%). In terms of negative interactions with their support person, the most frequently reported emotion was feeling sad (93.2%), and a few (8.2%) indicated that their primary source of support made them feel upset.

The majority of the respondents (84.9%) reported that their primary source of support was more giving than they themselves were and 87.6% felt they received about adequate or more than enough amounts of support. Many (83.6%) also found the support

to be satisfactory. More than two thirds (68.5%) of the respondents felt they had enough control over their life in the nursing home.

Study findings in the bivariate and multivariate analyses further indicated that social support received by the respondents had a predictive value regarding their health status. Social network, social support functions/contents, negative social interactions, directions of support, subjective measures of the support transactions, and perceived control were found to have a main or interactive effect in the regression models.

This chapter includes four parts: 1) discussion of the major findings relating to the research questions; 2) implications for social work practice; 3) limitations of the study; and 4) directions for future research.

Discussion of the Major Findings

Social Support and ADL Impairments

One of the interesting findings in this study was that only religion, among all the study demographic variables, was related to ADL impairments among Korean American nursing home residents. Protestant residents reported marginally higher ADL scores than Catholic and Buddhist residents. In other words, higher ADL socres indicate higher ADL impairments, therefore, the findings indicated that Catholic and Buddhist residents fared better than their Protestant counterparts. Other demographic variables, such as gender, did not show any significant association with ADL impairments, which was contrary to findings in previous research studies showing a relation between demographic factors and functional impairments (Murtagh & Hurbert, 2004; Wray & Blaum, 2001).

Bivariate analysis on social support and ADL impairments of Korean American nursing home residents showed that the appraisal support variable was significantly associated with ADL impairments. Korean American residents who obtained positive appraisal from their source of support person reported lower ADL impairments. However, frequency of support (visitation or phone contact) was not significantly associated with ADL impairments. This finding is opposite to Greene and Monahan's (1982) study which indicated that frequency of support (visitation) had a significant positive relationship with ADL impairments.

ADL impairments were also associated with health status (number of diseases and continence). Korean American residents reporting more diseases and more incontinence showed higher ADL impairments. This finding is consistent with previous studies, indicating that disability and chronic medical conditions can limit mobility and decrease functional independence (Cumming et al., 2000; Reid et al., 2005; Rissanen et al., 1996; Rolland et al., 2007; van Wijk et al., 2006).

Results from the Pearson correlation procedures showed positive and significant associations between psychosocial well-being variables (such as number of activities and initiatives) and ADL impairments among Korean American nursing home residents. Korean American residents who were active in program activities and engaged in numerous initiatives reported lower ADL impairments. The mutually reinforcing relationship between these variables demonstrates the importance of maintaining higher levels of social activity and engagement and ADL functioning for Korean American residents. Interventions that create opportunities for the resident to initiate social

interaction with other residents and to be involved in planned or structured program activities, may be beneficial in lowering ADL impairments.

ADL impairments were also associated with perceptions of control. Korean American nursing home residents who believed that they had enough control reported fewer ADL impairments. In other words, an increase in perceived control was associated with a decrease in ADL impairments. This finding is in line with previous studies (Jang et al., 2006b) showing a correlation between perceived control and physical health among 230 older Korean Americans in Florida. The association between perceptions of control and health is intriguing as perceptions of control, referring to the subjective experience of a resident's ability to manipulate the environment (Schieman, 2001; Zarit et al., 2003), would be closely tied to one's physical independence and capacity for self-care. Interventions that increase perceptions of control might enhance ADL functioning and independence among Korean American nursing home residents.

Results from independent samples t-tests showed that having a private phone in the resident's room was significantly associated with ADL impairments. Korean American nursing home residents who had a private phone in their room reported fewer ADL impairments than those who did not have a private phone.

In the regression model, level of social engagement (total number of initiatives) and health status (mean continence) were found to have predictive value for ADL impairments among Korean American nursing home residents. This finding is consistent with previous studies (Mor et al., 1995), demonstrating a statistically significant correlation between the levels of social engagement and ADL impairments. Residents with fewer ADL impairments were more likely to be socially engaged in initiatives in the

nursing home than residents with greater ADL impairments. Residents with fewer initiatives appeared to be more vulnerable to negative health outcomes. However, none of the social support variables significantly predicted ADL impairments among Korean American nursing home residents in the regression model. In addition, the interactive effects of frequency, negative behaviors, and perceptions of control did not significantly predict ADL impairments. Similarly, none of the main effects significantly predicted ADL impairments.

Social Support and Depressive Symptoms

At the bivariate level, the results indicated that several social support variables were significantly associated with depressive symptoms of Korean American nursing home residents. Appraisal support and satisfaction with support person were negatively associated with depressive symptoms. In other words, when the support persons made the residents feel accepted/complimented or when the residents felt supported by the support persons, Korean American nursing home residents reported fewer depressive symptoms. This finding is consistent with previous studies indicating that social support is an important factor in the mental health of nursing home residents (Segal, 2005). Social support functions, such as appraisal support, were significantly and negatively correlated with depressive symptoms (Nelson, 1989), indicating that perceptions of support from family were negatively related to depressive symptoms (Commerford & Reznikoff, 1996). However, instrumental support behaviors were directly associated with depressive symptoms. In other words, when the support persons just managed bank accounts or did errands for Korean American nursing home residents, they reported higher depressive

symptoms. This study finding is not consistent with previous studies which demonstrated, that emotional and instrumental support from their adult children was a significant negative predictor of depressive symptoms among Korean American elders (Mui, 2001).

Depressive symptoms are also associated with health status (number of diseases and continence). Korean American residents with more diseases and incontinence showed more depressive symptoms. One of the interesting findings in the demographic section was that none of the demographic variables was significantly associated with depressive symptoms. Results from one-way analysis of variance (ANOVA) showed that the length of stay in the current facility was marginally associated with depressive symptoms, indicating that Korean American residents with more years in the current facility had more depressive symptoms.

In the regression model, four social support variables were found to be predictive of depressive symptoms of Korean American nursing home residents: negative behaviors; perceptions of control; frequency interacting with negative behaviors; and negative behaviors interacting with perceptions of control. Korean American residents who believed they did not have enough control showed significantly higher depressive scores than those who believed they had enough control. This study finding is consistent with previous studies, demonstrating that perceived control had a beneficial effect on depressive symptoms, with statistical significance sustained even after controlling for the effects of chronic conditions and functional disability among 230 Korean Americans in Florida (Jang et al., 2006b). It appears that maintaining a sense of autonomy and independence is an important component of positive mental health. Therefore, the

importance of enhancing the Korean American nursing home residents' sense of control over their lives should be a treatment goal for depression-prone residents.

In addition, negative behaviors (such as being hurt or being upset) by a support person captured the affective component of negative social interaction. Negative behaviors that occur within an important ongoing relationship have a strong association with increased depression (Pagel, Erdly, & Becker, 1987). The current study's findings indicated that Korean American nursing home residents in negative relationships were more likely to experience depressive symptoms. From a treatment perspective, clinical intervention should focus on alleviating feelings of being sad or hurt, reducing conflict among nursing home residents and support persons, and addressing depressive symptoms. There are many avenues for intervention: individual counseling with the resident coupled with medication treatment, if needed, and conjoint counseling with the resident and the source of social conflict (i.e., family). The study's descriptive findings on health utilization revealed that about 48% of the respondents took at least one or two psychotropic medications and 35.6% of the respondents received psychological services on a weekly basis.

In terms of the interactive effects, the study findings indicated that negative behaviors moderated the effect of frequency of interactions/visits on depression scores. In other words, the more frequently the support person visited or interacted with the resident, the lower was the depression score of the resident. Negative behaviors also moderated the effect of perceptions of control on depression scores. In other words, those who believed they had enough control had lower depression scores than those who felt they did not have enough control.

Three control variables also significantly predicted depressive symptoms: number of initiatives; religion; and age. The fewer initiatives respondents participated in and the older the respondents, the higher were their depression scores. With respect to social activity, results were similar to previous studies with Korean American elders in the community (Choi, et al., 2008; Jang & Chiriboga, 2011; Yang et al., 2007) in that social activity was found to have positive benefits for depressive symptoms. This finding also confirmed numerous previous studies on social activity and depressive symptoms in that greater participation in social activities has been correlated positively with reduced depressive symptoms (Buchman et al., 2009; Glass et al., 2006; Hong et al., 2009; Isaac et al., 2009; Kiely & Flacker, 2003; Kiely et al., 2000; Lawton & Parmelee, 1995; Meeks et al., 2007; Morrow-Howell et al., 2003; Perkins et al., 2008; Spector & Takada, 1991).

With respect to religion and depressive symptoms, this finding is similar to previous studies in that religious involvement is correlated with fewer depressive mood symptoms, less anxiety, and better emotional adjustment among older adults (Ellison, 1991; Koenig et al., 1997; Koenig et al., 2001; Matthews et al., 1993; McCullough & Larson, 1999; Stuckey, 2001; Yoon & Lee, 2004, 2007). This study finding was also similar to previous studies with Korean American elders which showed that religious support can be a potential protective indicator in alleviating depressive symptoms (E. O. Lee, 2007). In this current study, a majority of Korean American nursing home residents were Protestant (65.8%) and Catholic (24.7%). Religious and spiritual support for Korean American nursing home residents is important as religious involvement provides a sense of security and psychological well-being. Therefore, the facility and staff should respect

residents' religions and religious values and create environments that support their religious or spiritual needs.

Social Support and Self-rated Health

At the bivariate level, the results indicated that several social support variables were significantly associated with depressive symptoms among Korean American nursing home residents: appraisal support; negative emotions; perceptions of giving; perceptions of support; and satisfaction with support person. Korean American residents who received positive appraisal from their support person, perceived themselves as having enough support and who were satisfied with the support they received, were more likely to have positive self-rated health scores. Korean American residents who rate their overall health higher may differ in important ways from residents who give lower self-health ratings. Residents with higher self-rated health may perceive their health and their social interactions/relationships in a more positive way. They may perceive reciprocity and symmetry in their social relationships.

Self-rated health is also associated with health status (number of diseases, number of cognitive deficits, and continence). Korean American residents with more diseases, more cognitive deficits, and more incontinence showed lower self-rated health scores. Two of the demographic variables, age and religion, were significantly associated with self-rated health. In addition, results from the Pearson correlation procedure and independent samples t-tests showed that several psychosocial variables, such as number of activities and initiatives, having a phone, and focus on control were significantly associated with the self-rated health of Korean American nursing home residents.

Residents participating in more activities and initiatives, and having a private phone in their room, had higher self-rated health scores. One of this study's interesting findings was that focusing on past roles was a negative risk factor for self-rated health. This may be explained by a resident who focuses upon the past roles-when he/she resided in the community and was presumably healthier or had higher status. Such a person is more likely to rate their current health as poorer by comparison.

In the regression model, two social support variables were found to be predictive of self-rated health of Korean American nursing home residents: perceptions of control and negative emotions/behaviors. Korean American residents who believed they did not have enough control had significantly lower health ratings than those who believed they had enough control. In other words, residents who feel they have enough control over their lives will rate their overall health as higher than residents who experience lower perceptions of control. A sense of personal control, choice, and autonomy are important concerns in the lives of the nursing home residents (Kane et al., 1997). The ability to make a choice regarding everyday matters will facilitate the individual's sense of personal well-being and self-rated health. A reciprocally reinforcing relationship will result, whereby higher self-rated health will engender feelings of greater personal control.

However, the interactive effects of frequency, negative behaviors, and perceptions of control did not significantly predict self-rated health among nursing home residents. Perceptions of control was the only variable that significantly predicted self-rated health among these Korean American nursing home residents.

Three control variables also significantly predicted the self-rated health of Korean American nursing home residents: number of initiatives; continence; and age. Residents

with higher incontinence scores and older residents were more likely to have lower self-rated health scores. With respect to number of initiatives and self-rated health, residents participating in a number of initiatives were more likely to have higher self-rated health score.

The Meaning of Social Support

This present study explored the social support networks of Korean American nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators.

Several interesting observations can be made from the analysis of social support and three health status variables: ADL impairments; depressive symptoms; and self-rated health. First, it is revealing to examine the social support variables that were *not* statistically significant. The relationship between source of support and many specific support functions/tasks were not statistically significant in the bivariate or regression analysis. This lack of significance may be attributable to the many similarities the Korean American nursing home residents shared: the vast majority of support indicated was family, and support persons resided within 25 miles of the nursing home. It is possible that distinctions between support persons were not distinguishable with the present data. Similarly, the support functions/tasks were not statistically correlated with the health status indicators.

Second, the social support predictors differed across the three health status indicators. Only one social support variable (perceptions of control) was significantly associated with all three dependent variables. Negative emotions/behaviors and

perceptions of control were associated with depressive symptoms and self-rated health. As mentioned earlier, a growing number of studies have shown the importance of autonomy for older adults, particularly nursing home residents (Anderson & Puggaard, 2008; Cohen-Mansfield, 1990; Cohen-Mansfield et al., 1995). The sense of control provides positive effects on nursing home residents' well-being and mental health.

With regard to perceptions of control among Korean American nursing home residents, unlike Western societies where autonomy and independence are highly valued, the familism and filial piety often found in Asian societies may help people accept an aging parent's increasing dependency upon adult children (Jang et al., 2006b). However, cultural and personal values have undergone transformations, and studies now report that Asian American elders have a strong desire for self-independence (Chou & Chi, 2001; Jang et al., 2006b). In order to facilitate the autonomy of Korean American nursing home residents, staff should respect and support their actions and choices. In addition, residents, as well as and their families, should be involved in decision-making regarding their own care, which may help increase Korean American residents' well-being and quality of life.

Third, it is instructive that most of the social support variables were not statistically significant at the bivariate level. Only one social support variable (appraisal support) was significantly associated with all three dependent variables. Korean American nursing home residents who obtained positive appraisal from the source of support were more likely to have higher ADL functioning and self-rated health scores, and lower depression scores.

Fourth, the number of initiatives and number of activities are important variables for affecting ADL functioning, depressive symptoms, and self-rated health among

Korean American nursing home residents. The results indicate the importance of maintaining high levels of engaging social activities. These findings also indicate that every effort should be made by nursing home staff to provide social activities and programs for Korean American nursing home residents. Involvement in activities is significantly important for nursing home residents to enhance "well-being and maintain function, social interaction, and connection to health and familiar aspects of their past" (Day & Cohen, 2000, p. 372). Therefore, social activities that offer enjoyment, affiliation, and a sense of cummunity to Korean American nursing home residents are an excellent method of optimizing social engagement and social support. As mentioned earlier, it appears that the majority of the Korean American nursing home residents have a religious identification (Park & Kang, 2007). Numerous studies suggested that religious support is positively associated with depressive symptoms and the quality of life for elderly Korean American immigrants (E. O. Lee, 2007; Lee & Chan, 2009; Park et al., 2011; Roh, 2010). Providing religious supports or opportunities for religious practice for Korean American nursing home residents is very important in maintaining their well-being. Therefore, attention should be paid at a community level to maximize the benefits of religious resources in order to enhance quality of life among Korean American nursing home residents.

Implications for Social Work Practice

The study findings have important implications for social workers in the field of gerontology. Social workers who assist in nursing home placement or who provide direct

services to Korean American nursing home residents play an important role in facilitating the social support and health-related quality of life of nursing home residents, including ethnic minority nursing home residents.

Studies demonstrated that the nursing home transition process is one of the most traumatic, stressful, and challenging periods experienced by both older adults and their families (Dellasega & Mastrian, 1995; Nolan & Dellasega, 2000; Reuss, Depuis, & Whitfield, 2005). Some researchers conceptualized the transition experiences as a multi-phased process, arguing that different types of support and intervention might be needed at differents stages throughout the transition (Lundh & Sandberg, & Nolan, 2000; Penrod & Dellasega, 2001; Reuss et al., 2005). Throughout the early phase of nursing home placement, including pre-placement planning, the initial stage of transition to institutional care, it is critical to educate both Korean American nursing home residents and their families regarding the meaning of the caregiving role for families and the benefits of social support. Korean American nursing home residents and their family members experience admission to a nursing home setting as a crisis. Among Korean American elders, nursing home placement could be seen as family disregard for filial piety and the result of elders being abandoned by their children (Park & Kang, 2007). To ethnic minority elders, including Korean American elders, nursing home placement implies a "second immigration" process (Kolb, 1999). Therefore, providing support groups for new residents and their families who are experiencing emotional difficulties may help ease the placement transition (Nolan & Dellasega, 2000; Reuss et al., 2005). It is also instructive for family members to understand early on that their support of Korean American nursing

home residents remains pivotal to the resident's physical, psychological, and psycho social well-being after the placement occurs.

Education of staff regarding the beneficial aspects of social support is another avenue for social work intervention. Staff has a vital role to play as gatekeepers to the nursing home. In-service staff training should be encouraged in order to educate staff about the importance of offering social support to the residents and of considering cultural uniqueness and other relevant factors in providing services to Korean American nursing home residents and their families (Park & Kang, 2007).

The findings of this study clearly point to the value of providing opportunities for social activities for Korean American nursing home residents as social activities are important variables affecting ADL functioning, depressive symptoms, and self-rated health among Korean American nursing home residents. Social engagement is more important among older individuals who have disability and disease than among those who are not disabled (Jang et al., 2004). Older individuals with disability may compensate for their lower physical function by placing more emphasis on social activities, which help improve the quality of life of older populations with limited physical function (Jang et al., 2004). This indicates that more attention should be paid to facilitate participation in social activities by the more physically impaired Korean American nursing home reisdents.

Social workers need to work with residents to develop support systems that include relatives, religious organizations, and community-based Korean American associations (Park & Kang, 2007). This endeavor can help Korean American nursing

home residents to adjust to a nursing home setting, develop meaningful social relationships with other residents, and improve their quality of life in the nursing home.

Limitations of the Study

Although some of the limitations of the study were already mentioned in the discussion section, this section explicates others. The first limitation derives from the study's design and sample size. A convenience sample of seventy-three participants is large enough for multivariate analysis but sampling size and strategy may limit the generalizability of the study findings. The participants for the study were selected from two nursing homes in Queens, New York. Therefore, caution must be taken in generalizing the results of the study. To improve the generalizability of the results, the study should be replicated using random sampling methods and include the various elderly nursing home populations drawn from various geographic locations.

A second limitation of the study involves the sampling criteria. The sampling criteria set high standards for study inclusion. Only residents with the highest cognitive and mental functioning were included in the sample. As a result, the study sample is higher-functioning than the typical nursing home population: the participants have less cognitive impairment and fewer psychological and behavioral problems. Therefore, they represent only a small section of the nursing home population.

Third, the social support questionnaire presents an additional study limitation. The questionnaire employed in this study has not yet been tested for reliability and validity. There is, however, a strong need for developing social support scales that address the

unique social support dimensions of nursing home populations, including Korean American nursing home residents. This study attempted to meet this need with the development of a questionnaire that took these issues into account.

Fourth, the social support questionnaire (SSQ) was translated from English into Korean and then administered to eligible Korean American nursing home residents. Although this study utilized the SSQ that was carefully translated through an appropriate back-translation process, the validity of the translated measurements with this population is still unknown.

A final limitation of the study is the reliance on secondary data regarding the health status of the participants. Although the MDS is a potentially powerful tool for implementing standardized assessment in nursing homes, the MDS was the sole source of information for quality of life indicators of the Korean American nursing home residents in this study. As with any secondary data source, the MDS had conceptual and methodological limitations. Another problem inherent to secondary data analysis involves the construct and design of the items. The items may not precisely match the research objectives of the current study.

Directions for Future Research

Based on the results and limitations of this study, there are several implications for future research that are illuminated in the findings. First, additional research is needed regarding the role of negative emotions/behaviors. There is a lack of elementary data regarding the impact of negative emotions/behaviors, such as the nature of conflicting

interactions, the intensity of the impact, its duration, its cumulative effect, and whether there exists a critical threshold beyond which the impact loses its significance to health outcomes (Rook, 1997). The present study demonstrated that being sad and upset, and having conflict exchanges, can be modified by social support behaviors. Further research could describe the qualities of the negative exchanges.

Second, this study expands our understanding of important social support variables to affect the quality of life among Korean American nursing home residents. Among important social support variables, perceived control was found to be predictive of the quality of life indicators among Korean American nursing home residents.Although a growing number of studies have demonstrated the importance of autonomy for older adults (Anderson & Puggaard, 2008; Cohen-Mansfield et al., 1995; Jang et al., 2006b, Jang et al., 2009), relatively little research has been conducted on perceived control for Korean American nursing home residents. Therefore, future research should explore the determinants of perceived control and interventions designed to promote perceived control among Korean American nursing home residents.

Third, the Minimum Data Set (MDS) is a uniform instrument used in nursing homes to assess residents. The MDS 2.0 was used in this study for collecting health data for Korean American nursing home residents. Due to lack of reliability, validity, and relevance of the MDS 2.0 version, a new MDS 3.0 was designed to give residents voice and to improve measurement reliability, accuracy, validity, efficiency, clarity, and clinical relevance (CMS 2008a, 2008b; Rahman & Applebaum, 2009; Saliba, 2008). The MDS 3.0 requires resident interviews with scripted questions, which prevent possible selection and response bias (Saliba, 2008). The MDS 3.0 has been recently implemented

in nursing homes. Future research is needed to examine the social support and health related quality of life among Korean American nursing home residents involving data extraction from the MDS 3.0.

Fourth, in spite of several limitations, this study provides valuable and specific information on Korean American nursing home residents, their social support and health status. This study may also serve as a basis for culturally appropriate and accessible nursing home care services for an ever-growing Korean American older population. During the course of this study, the researcher found a dearth of general baseline data and information about social support and health indicators of Korean American nursing home residents in the United States. Thus, future studies need to continue examining this understudied, underserved, and rapidly growing population.

Fifth, this study is a quantitative study. The researcher may consider conducting a social support study of Korean American nursing home residents using an ethnographic study. Since the ethnographic method is good for providing in-depth information, it may contribute to a deeper understanding of social support and its characteristics in the socio-cultural context of Korean American nursing home residents. An erhnographic study may also assist in more accurately defining and analyzing different forms of social support, evaluating social support in its varied forms, and illustrate how it may be reconstructed in a nursing home setting.

Finally, relatively little research has been conducted on the social support networks of ethnic minority nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators. More studies are necessary that focus on the increasing ethnic minority populations

residing in nursing homes in the United States. Nursing home residents of each ethnic group also have unique cultural and language needs and preferences; thus, researchers should examine the differences and similarities regarding the social support networks of ethnic minority nursing home residents. This study can be an example for future studies of these populations and can be extended to other ethnic groups.

APPENDICES

APPENDIX A

Cover Letter: To the Administrator

Date:

Re: Permission for nursing home resident participation in a research study

Dear Administrator:

I am a doctoral student in the CUNY Graduate Center's Social Welfare Program, pursuing a doctoral dissertation examining the relationship between social support and health-related quality of life among Korean American nursing home residents. This study will examine the social support networks of Korean American nursing home residents, the nature of their interpersonal transactions, and the association between social support and quality of life indicators.

I am requesting permission for access to your facility because the resident population is predominantly Asian American with a large number of Korean Americans. Seventy-five to 100 residents will be invited to participate in the study, which includes being interviewed regarding their social support systems and gaining access to their health records. To participate in this study, the resident must be cognitively capable of understanding the study questions and the consent form. The interview will take approximately 30-40 minutes and will be scheduled at a time and venue within the nursing home that is convenient to nursing home care and treatment. I also request permission from your facility to access the resident's medical record (MDS) for information on health status. All data collected will be kept confidential.

If you decide to permit your facility to be included in the study, I will need to obtain a letter of cooperation from you. I will contact you within two weeks to follow up. In the mean time, if you have any questions about the study or its procedures, please feel free to contact me at (917) 609-9093 and/or via e-mail at ssysu@hotmail.com. Thank you for your kind attention to this matter.

Sincerely yours,

Su-Jeong Park, MSW

APPENDIX B

Recruitment: Oral Script (English)

Hi, how are you? My name is Su-Jeong Park. I am a doctoral student in the CUNY Graduate Center's Social Welfare Program. I am currently working on my dissertation examining the relationship between social support and health-related quality of life among Korean American nursing home residents. Your name was given to me by this facility, which has permitted the study to be conducted at their facility. It is anticipated that approximately 75-100 residents will participate.

Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time. You may also refuse to answer any questions you don't want to answer and still remain in the study. Your decision to participate or not participate will not affect your standing in the nursing home or relationship with staff.

If you agree to participate, you will be interviewed for about 30-40 minutes. You will be given a questionnaire to read along with as I ask you questions about the personal support and help you receive from people in your life. I would also like permission to obtain health information from your medical record. Your participation, interview answers, and health data will be kept confidential.

The findings from the study will be used to write my doctoral dissertation. The findings may also be used for publication in professional journals. However, I will not write anything that can be used to identify you as an individual. If you are interested in the results of the study, I'd be willing to inform you of the research findings after the study has been conducted.

Do you want to participate in this study?

If yes: Great! Can we decide on a time and place to meet for the interview?

We will be meeting at _____ on _____at_____. I will confirm with you by phone the day before we meet. If you have any questions, I can be reached at (917) 609-9093.

If no: Remember, you have a right to refuse to answer any question at any time or withdraw from the study without penalty. However, participating in the study may increase our knowledge of the relationship between social support and the health of Korean American nursing home residents. Does this ease your mind about participating in the study?

Thank you so much for your time and cooperation.

APPENDIX B

Recruitment: Oral Script (Korean)

안녕하세요. 제 이름은 박수정입니다. 저는 뉴욕 시립 대학교 대학원 사회복지학과 박사 과정 학생입니다. 저는 현재 재미 한인 양로원 거주자 분들의 사회 지지(지원)와 건강과 관련된 삶의 질의 관계에 관한 논문을 쓰고 있습니다. 저는 귀하의 이름을 연구 허가서를 받은 이 양로원으부터 얻었습니다. 대략 75-100 분 정도 되시는 거주자분들이 참여하게 됩니다.

귀하의 참여는 전적으로 자발적입니다. 귀하는 언제든지 연구에 대한 참여 거부나 철회를 하실 수 있습니다. 귀하는 대답하고 싶지 않은 질문에는 거부를 하셔도 되고, 계속 연구에 참여하실 수 있습니다. 귀하의 참여나 참여 거부에 관한 결정이 양로원 또는 직원과의 관계에 영향을 끼치지 않을 것입니다.

만약 귀하께서 참여하는 것에 동의 하신다면, 귀하는 30-40 분 정도가 소요되는 면접(인터뷰)을 하게 될 것입니다. 귀하께서는 설문지를 받고, 저는 귀하의 개인적인 지지(지원)와 사람들로부터 받으시는 도움에 관한 질문들을 하게 될 것입니다. 그리고 저는 귀하의 의료 기록에서 건강에 관련한 정보를 수집하는 것에 대한 허가를 원합니다. 귀하의 참여, 인터뷰 대답들, 그리고 의료 기록에 대해서는 비밀이 보장 될 것입니다.

연구 결과는 박사 논문으로 사용될 것입니다. 그리고, 전문 학술지의 간행물로도 사용될 수도 있습니다. 그러나, 저는 개인적으로 귀하를 확인할 수 있는 그 어떤 것도 쓰지 않을 것입니다. 만약 귀하께서 연구 결과에 대해 관심이 있으시면, 연구가 진행된 후에 조사 결과에 대해 알려 드리겠습니다.

이 연구에 참여하기를 원하십니까?

만약 참여를 원하신다면, 좋습니다! 면접(인터뷰)을 할 시간과 장소를 정할까요?

저와 귀하는 _____일 _____시에_____에서 만나게 될 것입니다. 제가 이틀 전에 확인 전화를 드리겠습니다. 혹시 질문이 있으시면, (917) 609-9093 으로 연락 주십시오.

만약 참여를 거부하신다면, 기억하십시오. 귀하는 언제든지 질문에 대답하지 않을 권리를 가지고 계시며, 연구 참여 철회로 인한 어떠한 불이익도 주어지지 않습니다. 하지만, 귀하의 연구 참여는 재미 한인 양로원 거주자분들의 사회

지지(지원)와 건강과 관련된 삶의 질의 관계에 관한 지식을 증진하는데 계기가 될 것입니다. 이것이 연구에 참여하는 귀하의 마음을 편하게 합니까?

귀하의 시간과 협조에 감사드립니다.

APPENDIX C

Consent Form (English)

My name is Su-Jeong Park and I am a student in the CUNY Graduate Center's Doctorate in Social Welfare Program. I am conducting a study to examine how personal support from important persons can affect the health of Korean American nursing home resident.

You are being asked to participate in this study because you are a Korean American residing in a nursing home who is at the age of 65 and older. It is anticipated that approximately 75-100 individuals will participate in this study.

Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from participation at any time without penalty or loss of benefits or services to which you are entitled. You may also refuse to answer any questions you don't want to answer and still remain in the study. Your decision to participate or not participate will not affect your standing in the nursing home or relationship with staff.

If you volunteer to be in this study, I would ask you to do the following things;

- Before the interview begins, you will be given the study consent form to read and sign. If you cannot read, the form will be read to you.
- The consent form will be explained to you in detail.
- You will be assured that all study results will be completely confidential and that you are under no obligation to participate. You will also be informed that you can withdraw from the study at any time.
- You will then be asked to complete a questionnaire. If you want, the questions will be read to you by the researcher in Korean in order for you to better understand survey questions. Interview is expected to last about 30-40 minutes.
- You will be asked questions about the personal support and help which you receive from the people in your life.
- You may feel uncomfortable with some of the questions. If you do feel uncomfortable, you may refuse to answer any questions or stop the interview at any time for any reason.
- I will also need to obtain medical information that the nursing home keeps in what's called the MDS (Minimum Data Set) in order to conduct the study and am asking permission to gather that information. Medical information contains physical functioning, continence, psychosocial well-being, mood and behaviors, diagnoses, nutritional status, skin condition, and medications. It will also be kept confidential.

All materials related to this study will be kept in a locked filing cabinet in the faculty advisor's locked office to which only my advisor and I have access. All research materials and the data will be stored for a minimum of three years, after which they will be destroyed.

A potential benefit is that you may make a contribution to help understand how social support from important persons can affect the health-related quality of life of Korean American nursing home residents. The findings from the study will be used to write my doctoral dissertation. The findings may also be used for publication in professional journals. If you are interested in results of the study, I'd be willing to inform you of research findings after the study.

If you have any questions about this study, you may contact me at (917) 609-9093 or by e-mail at ssysu@hotmail.com or my advisor, Dr. Bernadette R. Hadden at (212) 396-7545 or by bhadden@hunter.cuny.edu. If you have any questions about your right as a research subject in this study, you can contact Kay Powell, IRB administrator, The Graduate Center/The City University of New York, at (212)817-7525.

Thank you so much for your participation in the study.

I understand the contents of this consent form and the procedures described above. I have been encouraged to ask questions and have received answers to my questions. I agree to participate in this study. I have received (or will receive) a copy of this form.

I give my permission for you to access my medical information at the nursing home. Please circle one.

Yes ***No***

_____ _____

Signature/Initial of Participant or Legal representative Date

_____ _____

Signature of Investigator Date

APPENDIX C

Consent Form (Korean)

연구 조사 참여 동의서

저는 뉴욕 시립 대학교 대학원 사회복지학과 박사 과정에 있는 박수정입니다. 저는 현재 중요한 사람들로 부터 받는 사회 지지(지원)가 양로원에 거주하고 있는 재미 한인 노인의 건강에 어떤 영향을 가져다 주는가에 대한 연구를 하고 있습니다.

귀하께서는 현재 양로원에 거주하고 계시는 한인 노인이시며, 65 세 또는 그 이상의 연세이기 때문에 이 연구에 참여하게 되셨습니다. 대략 75-100 분 정도 되시는 거주자분들이 이 연구에 참여하게 됩니다.

귀하의 참여는 전적으로 자발적입니다. 귀하는 언제든지 참여 거부나 철회를 하실 수 있고, 참여 거부나 철회로 인한 어떠한 불이익도 주어지지 않습니다. 귀하는 대답하고 싶지 않은 질문에는 거부를 하셔도 되고, 계속 연구에 참여하실 수 있습니다. 귀하의 참여나 참여 거부에 관한 결정이 양로원 또는 직원과의 관계에 영향을 끼치지 않을 것입니다.

귀하께서 이 연구에 참여 하신다면, 다음과 같은 절차에 의해 진행이 됩니다;

- 면접 조사를 시작하기 전에, 연구 동의서를 읽으시고 서명을 하시게 됩니다. 만약 한글을 읽지 못하시는 경우에, 연구 조사자가 동의서를 읽어 드리겠습니다.
- 연구 조사자가 동의서에 대해 자세하게 설명해 드릴 것입니다.
- 이 연구의 결과는 절대 비밀이 보장될 것이며, 귀하께서는 참여하실 의무가 없음을 알려 드립니다. 또한 원하지 않으시면, 이 연구에서 언제든지 철회 하실 수 있다는 것을 알려 드릴 것입니다.
- 그 이후에 설문지를 작성하게 됩니다. 귀하께서 원하시면, 연구 조사자가 설문 조항을 잘 이해하실 수 있도록 한국어로 설문지를 읽어드릴 것입니다. 전체 소요 시간은 30-40 분이 될 것입니다.
- 귀하는 귀하의 개인적인 지지와 사람들로부터 받으시는 도움에 관한 질문들을 받게 됩니다.
- 귀하는 몇 가지 설문 문항으로 인해 불편함을 느끼게 될 수도 있습니다. 만약 불편함을 느끼시면, 응답하지 않으셔도 되고 어떠한 이유에서든지 설문 조사를 중단하실 수 있습니다.
- 저는 이 연구를 위해서 양로원으로부터 귀하의 의료 기록을 수집하게 될 것이며, 그 정보를 수집하는 것에 대한 허가를 원합니다. 의료 기록에는 귀하의 육체적인 기능, 배변, 심리사회적 행복, 정신과 행동, 진단, 영양 상태,

피부 상태, 그리고 약등에 관한 정보가 포함이 됩니다. 그리고, 의료 기록은 비밀이 보장될 것입니다.

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이 연구에 참여에 주셔서 감사드립니다.

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예 아니오

_____ _____

연구 참여자 또는 법적대리인의 서명 날짜

_____ _____

연구조사 책임자의 서명 날짜

APPENDIX D

MINIMUM DATA SET (MDS) – VERSION 2.0

For Nursing Home Resident Assessment and Care Screening
Basic Assessment Tracking Form

Health Status Data

Date of MDS: Full _____
Date of MDS: Quarterly _____

Section AA. Identification Information

1. Resident's ID#:_____

2. Facility ID#:_____

3. Gender (circle only one)
1. Male
2. Female

4. Resident's date of birth (Month/day/year):_____

Section B. Cognitive Patterns

5. Memory: Recall of what was learned or known (Circle only one)
0 = Ok 1 =Memory problem

a. Short-term memory OK-seems/appears to recall after 5 minutes	0	1
b. Long-term memory OK-seems/appears to recall long past	0	1

6. Cognitive skills for daily decision-making: Made decisions regarding tasks of daily life (Circle only one)
0. Independent-decisions consistent/reasonable
1. Modified independence-some difficulty in new situations only
2. Moderately impaired-decisions poor; cues/supervision required
3. Severely impaired-never/rarely made decisions

Section E. Mood and Behavior Patterns

7. Indicators of depression, anxiety, sad mood: Code for indicators observed in last 30 days, irrespective of the assumed cause (Circle all that apply)

    0. Indicator not exhibited in last 30 days
    1. Indicator of this type exhibited up to five days a week
    2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

a. Resident made negative statements	0	1	2
b. Repetitive questions	0	1	2
c. Repetitive verbalizations	0	1	2
d. Persistent anger with self or others	0	1	2
e. Self-deprecation	0	1	2
f. Expressions of what appears to be unrealistic fears	0	1	2
g. Recurrent statements that something terrible is about to happen	0	1	2
h. Repetitive health complaints	0	1	2
i. Repetitive anxious complaints/concerns (non-health related)	0	1	2
j. Unpleasant mood in morning	0	1	2
k. Insomnia/change in usual sleep pattern	0	1	2
l. Sad, pained, worried facial expressions	0	1	2
m. Crying, tearfulness	0	1	2
n. Repetitive physical movements	0	1	2
o. Withdrawal from activities of interest	0	1	2
p. Reduced social interaction	0	1	2

8. Behavioral symptoms (Circle all that apply)

    (A) Behavioral symptom frequency in last 7 days

    0. Behavior not exhibited in last 7 days
    1. Behavior of this type occurred 1 to 3 days in last 7 days
    2. Behavior of this type occurred 4 to 6 days, but less than daily
    3. Behavior of this type occurred daily

a. Wandering	0	1	2	3
b. Verbally abusive behavioral symptoms	0	1	2	3
c. Physically abusive behavioral symptoms	0	1	2	3
d. Socially inappropriate/disruptive behavioral symptoms	0	1	2	3
e. Resists care	0	1	2	3

Section F. Psychosocial Well-Being

9. Sense of Initiative/Involvement (Circle all that apply)
0 = No 1 = Yes

a. At ease interacting with others	0	1
b. At ease doing planned or structured activities	0	1
c. At ease doing self-initiative activities	0	1
d. Establish own goals	0	1
e. Pursues involvement in life of facility	0	1
f. Accepts invitations into most group activities	0	1
g. None of above	0	1
zz. Information not in chart	0	1

10. Unsettled relationships (Circle all that apply)
0 = No 1 = Yes

a. Covert/open conflict with or repeated criticism of staff	0	1
b. Unhappy with roommate	0	1
c. Unhappy with residents other than roommate	0	1
d. Openly expresses conflict/anger with family/friends	0	1
e. Absence of personal contact with family/friends	0	1
f. Recent loss of close family member/friend	0	1
g. Does not adjust easily to change in routines	0	1
h. None of above	0	1
zz. Information not in chart	0	1

11. Past Roles (Circle all that apply)
0 = No 1 = Yes

a. Strong identification with past roles and life status	0	1
b. Expresses sadness/anger/empty feeling over lost roles/status	0	1
c. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	0	1
d. None of above	0	1
zz. Information not in chart	0	1

Section G. Physical Functioning and Structural Problems

12. ADL self-performance: Code for resident's performance over all shifts during last 7 days- Not including setup

    0. Independent
    1. Supervision
    2. Limited assistance
    3. Extensive assistance
    4. Total dependence
    8. Activity did not occur

a. Bed mobility	0	1	2	3	4	8
b. Transfer	0	1	2	3	4	8
c. Walk in room	0	1	2	3	4	8
d. Walk in corridor	0	1	2	3	4	8
e. Dressing	0	1	2	3	4	8
f. Eating	0	1	2	3	4	8
g. Toilet use	0	1	2	3	4	8
h. Personal hygiene	0	1	2	3	4	8
i. Bathing	0	1	2	3	4	8

Section H. Continence in Last 14 Days

13a. Bowel continence: Control of bowel movement, with appliance or bowel continence programs, if employed (Circle only one)

    0. Continent
    1. Usually continent
    2. Occasionally incontinent
    3. Frequently incontinent
    4. Incontinent

13b. Bladder continence: Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence program, if employed (Circle only one)

    0. Continent
    1. Usually continent
    2. Occasionally incontinent
    3. Frequently incontinent
    4. Incontinent

Section I. Disease Diagnoses

14. Diseases (If none apply, check the none of the above box)
0 = No 1 = Yes

a. Diabetes mellitus	0	1	w. Multiple sclerosis	0	1
b. Hyperthyroidism	0	1	x. Paraplegia	0	1
c. Hypothyroidism	0	1	y. Parkinson's disease	0	1
d. ASHD	0	1	z. Quadriplegia	0	1
e. Cardiac dysrhythmias	0	1	aa. Seizure disorder	0	1
f. Congestive heart failure	0	1	bb. TIA	0	1
g. Deep vein thrombosis	0	1	cc. Traumatic brain injury	0	1
h. Hypertension	0	1	dd. Anxiety disorder	0	1
i. Hypotension	0	1	ee. Depression	0	1
j. Peripheral vascular disease	0	1	ff. Manic disorder	0	1
k. Other vascular disease	0	1	gg. Schizophrenia	0	1
l. Arthritis	0	1	hh. Asthma	0	1
m. Hip fracture	0	1	ii. Emphysema/COPD	0	1
n. Missing limb	0	1	jj. Cataracts	0	1
o. Osteoporosis	0	1	kk. Diabetic retinopathy	0	1
p. Pathological bone fx	0	1	ll. Glaucoma	0	1
q. Alzheimer's disease			mm. Macular degeneration	0	1
r. Aphasia	0	1	nn. Allergies	0	1
s. Cerebral palsy	0	1	oo. Anemia	0	1
t. Cerebrovascular accident	0	1	pp. Cancer	0	1
u. Dementia other than AD	0	1	qq. Renal failure	0	1
v. Hemiplegia/hemiparesis	0	1	rr. None of the above	0	1

Section J. Health Conditions

15. Accidents (Circle all that apply)
    0 = No 1 = Yes

a. Fell in past 30 days	0	1
b. Fell in past 31-180 days	0	1
c. Hip fracture in last 180 days	0	1
d. Other fracture in last 180 days	0	1
e. None of above	0	1

16. Stability of conditions (Circle all that apply)
    0 = No 1 = Yes

a. Conditions/disease make resident's cognitive, ADL, mood or behavior patterns unstable-(fluctuation, precarious, or deteriorating)	0	1
b. Resident expressing an acute episode or a flare-up of a recurrent or chronic problem	0	1
c. End-state disease, 6 or fewer months to live	0	1
d. None of above	0	1

Section K. Nutritional Status/Weight change

17a. Weight loss 5% or 10% (Circle only one)
    0. No
    1. Yes

17b. Weight gain 5% or 10% (Circle only one)
    0. No
    1. Yes

Section N. Activity Pursuit Patterns

18. Average time involved in activities: When awake and not receiving treatment or ADL Care (Circle only one)
    0. Most-more than 2/3 of time
    1. Some-from 1/3 to 2/3 of time
    2. Little-less than 1/3 of time
    3. None

19. General activity preferences (Check all preferences that apply)

    0 = No 1 = Yes

a. Cards/other games	0	1	h. Walking/wheeling outdoors	0	1
b. Crafts/arts	0	1	i. Watching TV	0	1
c. Exercise/sports	0	1	j. Gardening or plants	0	1
d. Music	0	1	k. Talking or conversing	0	1
e. Reading/writing	0	1	l. Helping others	0	1
f. Spiritual/religious activities	0	1	m. None of above	0	1
g. Trips/shopping	0	1			

Section O. Medications

20. Days received the following medication (Record the number of days during last 7days; enter "0" if not used. Note-enter "1" for long-acting meds used less than week (Check all that apply)

    0 = NO 1 = Yes

a. Antipsychotic	0	1
b. Antianxiety	0	1
c. Antidepressant	0	1
d. No medications	0	1

Section P. Special Treatments and Procedures

21. Psychological therapy: by any licensed mental health professional (Circle only one)
    0 = No
    1 = Yes

22. Intervention programs for mood, behavior, cognitive loss: Check all interventions or strategies used in last 7 days-no matter where received (Circle all that apply)

0 = No 1 = Yes

a. Special behavior symptom evaluation	0	1
b. Evaluation by mental health specialist in last 90 days	0	1
c. Group therapy	0	1
d. Resident-specific deliberate changes in the environment to address mood/behavior patterns	0	1
e. Reorientation-e.g., cueing	0	1
f. None of above	0	1
g. Information not in chart	0	1

23. Hospital stay(s): Record number of times resident was admitted to hospital with an overnight stay in last 90 days (Enter 0 if no hospital admissions)

_____

24. Emergency room visit(s): Record number of times resident visited ER without an overnight stay in last 90 days (Enter 0 if no ER visits)

_____

Section Q. Discharge Potential and Overall Status

Discharge Potential

25a. Resident expresses preferences to return to the community (Circle only one)
0. No
1. Yes

25b. Resident has a support person who is positive toward discharge (Circle only one)
0. No
1. Yes

25c. Stay projected to be of a short duration-discharge projected within 90 days (Circle only one)
0. No
1. Within 30 days
2. Within 31-90 days
3. Discharge status uncertain

Overall change in Care Needs

26. Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 days ago (Circle only one)
    0. No change
    1. Improved-receives fewer supports, needs less restrictive level of care
    2. Deteriorated-receives more support

Background (Face Sheet) Information at Admission

Section AB. Demographic Information

27. Date of Entry (month/day/year): _____

28. Admitted from (at entry) (Circle only one)
    1. Private home/apt with no home health services
    2. Private home/apt with home health services
    3. Board and care/assisted living/group home
    4. Nursing home
    5. Acute care hospital
    6. Psychiatric hospital, MR/DD facility
    7. Rehabilitation hospital
    8. Other

29. Lived alone (prior to entry) (Circle only one)
    0. No
    1. Yes
    2. In other facility

30. Life time occupation (Circle only one)
    1. Executive, managerial, professional
    2. Administrative support/clerical
    3. Sales, technical support
    4. Service industry
    5. Skilled work
    6. Semi-skilled work
    7. Transportation field
    8. Laborer
    9. Farming
    10. Military
    11. Homemaker
    97. Unknown

31. Education (Highest level completed) (Circle only one)
    1. No schooling
    2. 8th grade/less
    3. 9-11 grades
    4. High school
    5. Technical or trade school
    6. Some college
    7. Bachelor's degree
    8. Graduate degree

Section AC. Customary Routine

Customary Routine: In year prior to Date of Entry to this nursing home, or year last in community if now being admitted from another nursing home

32. Involvement Patterns (Circle all that apply)

0 = N0 1 =Yes

a. Daily contact with relatives/close friends	0	1
b. Usually attends church, temple, synagogue (etc.)	0	1
c. Finds strength in faith	0	1
d. Daily animal companion/presence	0	1
e. Involved in group activities	0	1
f. None of above	0	1
g. Unknown	0	1
h. Information not in chart	0	1

Section A. Identification and Background Information

33. Marital Status (Circle only one)
    1. Never married
    2. Married
    3. Widowed
    4. Separated
    5. Divorced

34. Current payment sources for N.H Stay (Circle all that apply)

0 = No 1 =Yes

a. Medicaid per diem	0	1
b. Medicare per diem	0	1
c. Medicare ancillary Part A	0	1
d. Medicare ancillary Part B	0	1
e. CHAMPUS per diem	0	1
f. VA per diem	0	1
g. Self or family for full per diem	0	1
h. Medicaid resident liability/Medicare co-payment	0	1
i. Private insurance per diem (including co-payment)	0	1
j. Other per diem	0	1

35. Religious Affiliation (Circle only one)

0. None
1. Catholic
2. Christian/Protestant
3. Jehovah's witness
4. Buddhist

APPENDIX E

Social Support Questionnaire (English)

1. Time start:_____
2. Resident ID#:_____
3. Facility ID#:_____

I will ask you about any recent changes in your life. You can answer with a "Yes" or a "No".

Environmental Change or Social Change

4. In the previous three to six months, have you changed rooms? (Circle only one)
   1. Yes 2. No

5. In the previous three to six months, have you had a new roommate? (Circle only one)
   1. Yes 2. No

6. In the previous three to six months, has someone close to you moved away? (Circle only one)
   1. Yes 2. No

7. In the previous three to six months, has someone close to you become ill? (Circle only one)
   1. Yes 2. No

8. In the previous three to six months, has someone close to you died? (Circle only one)
   1. Yes 2. No

Telephone Ownership

9. Do you have your own private telephone in your room? (Circle only one)
   1. Yes 2. No

Please think about the persons in your life who are living now and who are currently important to you. It can be family, relatives, friends, clergy, other nursing home residents, or staff here at the nursing home.

Social Network

**Please think one or two most important person in your life today:

10. Person #1: 1. Yes 2. No

11. Person #2: 1. Yes 2. No

For each person isted, I will ask you questions about that person:

Person#1: Social Network

Person#1

12. Relationship (Circle only one)
    1) Husband 2) Wife 3) Son 4) Daughter 5) Son-in-law 6) Daughter-in-law 7) Grandchild 8) Sister 9) Brother 10) Niece/Nephew 11) Sister-in-law 12) Brother-in-law 13) Other relatives 14) Friend 15) Co-resident 16) Nursing staff 17) Social work staff 18) Housekeeping staff 19) Other nursing home staff 20) Clergy person 21) Volunteer 22) Other 23) Don't know

13. How long have you known_____? (Circle only one)
    1. Less than 3-6 months
    2. 6-12 months
    3. 1-2 years
    4. 2-5 years
    5. 5 years or more

14. What is the distance between _____'s home and the nursing home? (Circle only one)
    1. Greater than 25 miles
    2. Less than 25 miles
    3. Same room
    4. Same floor

15. Since you've been in the nursing home, does_____ visit with you? (Circle only one)
    1. Yes 2. No

16. How often does_____ visit you? (Circle only one)
    1. About every day
    2. 1-3 times a week
    3. 1-2 times a month
    4. A few times a year
    5. Not at all

17. Is there a regular pattern to how often _____ visit? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

18. Since you have been in the nursing home, do you and _____ talk on the phone to each other? (Circle only one)
    1. Yes 2. No

19. How often do you talk on the phone with _____? (Circle only one)
    1. About every day
    2. 1-3 times a week
    3. 1-2 times a month
    4. A few times a year
    5. Not at all

20. Is there a regular pattern to how often you and_____ talk on the phone? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

21. Since you have been in the nursing home, do either you or_____ send letters or cards to one another? (Circle only one)
    1. Yes 2. No

22. How often does either of you send letters or cards to one another? (Circle only one)
    1. About everyday
    2. 1-3 times a week
    3. 1-2 times a month
    4. A few times a year
    5. Not at all

23. Is there a regular pattern to how often you and _____send cards or letters? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

The next question can be answered with a "Yes" or a "No". Many different behaviors happen in a relationship. Since you have been in the nursing home, has_____:

Person#1: Social Support Functions/Contents

24. Shown you physical affection
    Yes=1 No=2

25. Listened to you talk about your personal feelings
    Yes=1 No=2

26. Given you advice
    Yes=1 No=2

27. Updated you on personal and/or current events
    Yes=1 No=2

28. Made you feel accepted
    Yes=1 No=2

29. Complimented you on a personal quality of yours
    Yes=1 No=2

30. Made you feel upset or distressed
    Yes=1 No=2

31. Made you feel sad or hurt
    Yes=1 No=2

32. Managed your bank account, paid bills
    Yes=1 No=2

33. Done personal errands or chores for you (shopping, laundry, etc)
    Yes=1 No=2

These next questions are a little more complicated.

Person#1: Directions of Support

34. Relationships have a give and take. In your relationship with _____, would you say that: (Circle only one)
    1. You give more to_____ than he/she gives to you.
    2. _____gives more to you than you give to him/her.
    3. It's about 50-50 between you.
    4. I Don't know.

Person#1: Subjective Appraisals

35. Could you use more or less support from_____, or is it about right? (Circle only one)
    1. Less 2. More 3. About right 4. Don't know

36. Are you satisfied or dissatisfied with the overall support that you receive from_____? (Circle only one)
    1. Satisfied 2. Dissatisfied 3. Don't know

*****Now go to person #2 and complete items #37-61. If a person #2 was not identified, skip items #37-61 and go directly to item #62.**

Person#2: Social Network

Person#2

37. Relationship (Circle only one)
    1) Husband 2) Wife 3) Son 4) Daughter 5) Son-in-law 6) Daughter-in-law 7) Grandchild 8) Sister 9) Brother 10) Niece/Nephew 11) Sister-in-law 12) Brother-in-law 13) Other relatives 14) Friend 15) Co-resident 16) Nursing staff 17) Social work staff 18) Housekeeping staff 19) Other nursing home staff 20) Clergy person 21) Volunteer 22) Other 23) Don't know

38. How long have you known_____? (Circle only one)
    1. Less than 3-6 months
    2. 6-12 months
    3. 1-2 years
    4. 2-5 years
    5. 5 years or more

39. What is the distance between _____'s home and the nursing home? (Circle only one)
    1. Greater than 25 miles
    2. Less than 25 miles
    3. Same room
    4. Same floor

40. Since you've been in the nursing home, does_____ visit with you? (Circle only one)
    1. Yes 2. No

41. How often does_____ visit with you? (Circle only one)
    1. About every day
    2. 1-3 times a week
    3. 1-2 times a moth
    4. A few times a year
    5. Not at all

42. Is there a regular pattern to how often you and _____ visit? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

43. Since you have been in the nursing home, do you and _____ talk on the phone to each other? (Circle only one)
    1. Yes 2. No

44. How often do you talk on the phone with _____? (Circle only one)
    1. About everyday
    2. 1-3 times a week
    3. 1-2 times a month
    4. A few times a year
    5. Not at all

45. Is there a regular pattern to how often you and_____ talk on the phone? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

46. Since you have been in the nursing home, do either you or_____ send letters or cards to one another? (Circle only one)
    1. Yes 2. No

47. How often does either of you send letters or cards to one another? (Circle only one)
    1. About everyday
    2. 1-3 times a week
    3. 1-2 times a month
    4. A few times a year
    5. Not at all

48. Is there a regular pattern to how often you and _____send cards or letters? (Circle only one)
    1. Yes 2. No 98. Don't know 99. Not applicable

The next question can be answered with a "Yes" or a "No". Many different behaviors happen in a relationship. Since you have been in the nursing home, has_____:

Person#2: Social Support Functions/Contents

49. Shown you physical affection
    Yes=1 No=2

50. Listened to you talk about your personal feelings
    Yes=1 No=2

51. Given you advice
    Yes=1 No=2

52. Updated you on personal and/or current events
    Yes=1 No=2

53. Made you feel accepted
    Yes=1 No=2

54. Complimented you on a personal quality of yours
    Yes=1 No=2

55. Made you feel upset or distressed
    Yes=1 No=2

56. Made you feel sad or hurt
    Yes=1 No=2

57. Managed your bank account, paid bills
    Yes=1 No=2

58. Done personal errands or chores for you (shopping, laundry, etc).
    Yes=1 No=2

These next questions are a little more complicated.

Person#2: Directions of Support

59. Relationships have a give and take. In your relationship with _____, would you say that: (Circle only one)
    1. You give more to_____ than he/she gives to you.
    2. _____gives more to you than you give to him/her.
    3. It's about 50-50 between you.
    4. I Don't know.

Person#2: Subjective Appraisals

60. Could you use more or less support from_____, or is it about right? (Circle only one)
    1. Less 2. More 3. About right 4. Don't know

61. Are you satisfied or dissatisfied with the overall support that you receive from_____? (Circle only one)
    1. Satisfied 2. Dissatisfied 3. Don't know

***Resume here if person #2 is not listed.**

Perceived Control

62. Do you feel that you have enough control or not enough control over your life here? (Circle only one)
    1. Enough control 2. Not enough control 3. Don't know

Self-rated Health

63. How would you rate your overall health at the present time? (Circle only one)
    1. Poor 2. Fair 3. Good 4. Excellent

Chilren Living in the Community

64. Do you have any living children? (Circle only one)
    1. Yes 2. No

65. How many? (Write exact number): _____

66-70. How far away do they live? (25 miles)

66.	Child #1	1. More than 25 miles	2. Less than 25 miles
67.	Child #2	1. More than 25 miles	2. Less than 25 miles
68.	Child #3	1. More than 25 miles	2. Less than 25 miles
69.	Child #4	1. More than 25 miles	2. Less than 25 miles
70.	Child#5	1. More than 25 miles	2. Less than 25 miles

Thank you for your participation in this study. Answer #71-72, after interview is completed.

71. Interview location
    1. Resident room 2. Lounge/TV room 3. Recreation room 4. Dining room 5. Office 6. Outdoor 7. Hallway/corridor 8. Other

72. Were interviewing conditions conducive to privacy?
    1. Yes
    2. No (If no, explain:_____)

73. Time end:_____

APPENDIX E

Social Support Questionnaire (Korean)

사회 지원에 관한 질문서

1. 시작 시간:_____
2. 거주자 ID#:_____
3. 기관 ID#:_____

귀하의 삶에서 최근에 생긴 변화에 관해서 질문을 할 것입니다. "예" 또는 "아니오"로 대답해 주십시오.

환경 변화 또는 사회 변화

4. 지난 3-6 개월 동안에 방을 옮긴 적이 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

5. 지난 3-6 개월 동안에 새로운 룸메이트와 지내고 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

6. 지난 3-6 개월 동안에 귀하와 친분이 있는 사람이 먼 곳으로 이사를 간 적이 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

7. 지난 3-6 개월 동안에 귀하와 친분이 있는 사람이 아팠던 적이 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

8. 지난 3-6 개월 동안에 귀하와 친분이 있는 사람이 돌아가신 적이 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

개인 전화기 소유

9. 방에 개인 전화가 있습니까? (한 곳에만 표시)
   1. 예 2. 아니오

귀하의 인생에 중요하다고 생각되는 사람들을 생각하여 주십시오. 그 사람들은 귀하의 가족, 친척, 친구, 교회 관계자, 양로원 거주자들, 직원등이 해당될 수 있습니다.

<u>사회 관계</u>

**귀하의 인생에서 중요하다고 생각하는 사람들의 이름을 기입하여 주시기 바랍니다:

10. 첫 번째 사람의 이름:_____

11. 두 번째 사람의 이름:_____

귀하께 그 사람에 관해서 질문을 하겠습니다:

<u>중요한 사람#1: 사회 관계</u>

<u>중요한 사람#1</u>

12. 관계 (한 곳에만 표시)
    1) 남편 2) 아내 3) 아들 4) 딸 5) 사위 6) 며느리

    7) 손자/손녀 8) 자매 9) 형제 10) 조카 11)

    12) brother-in-law 13) 다른 친척들 14) 친구 15) 동료 거주자 16) 간호사

    17) 사회 복지사 18) 시설 관리과 19) 다른 너싱홈 직원

    20) 성직자 21) 자원 봉사자 22) 기타

13. 알고 지낸기간은 _____? (한 곳에만 표시)
    1. 3-6 개월 미만
    2. 6-12 개월
    3. 1-2 년
    4. 2-5 년
    5. 5 년 이상

14. 너싱홈과 그 사람의 집과의 거리는 _____?
    (한 곳에만 표시)
    1. 25 마일 이상

2. 25 마일 미만
3. 같은 방
4. 같은 층

15. 귀하께서 양로원에 입주하신 이후로 그 사람은 방문을 합니까?
(한 곳에만 표시)
1. 예 2. 아니오

16. 얼마나 자주 방문을 합니까? (한 곳에만 표시)
1. 매일
2. 일주일에 1-3 번
3. 한 달에 1-2 번
4. 일년에 몇 번
5. 전혀 방문 하지 않음

17. 그 사람이 방문을 하는데 정해진 패턴이 있습니까? (한 곳에만 표시)
1.예 2. 아니오 98. 잘 모르겠음 99. 해당 사항 없음

18. 귀하께서 양로원으로 오신 후 서로 전화 통화를 합니까? (한 곳에만 표시)
1.예 2. 아니오

19. 얼마나 자주 전화 통화를 합니까 _____? (한 곳에만 표시)
1. 매일
2. 일주일에 1-3 번
3. 한 달에 1-2 번
4. 일 년에 몇 번
5. 전혀 하지 않음

20. 귀하가 전화를 하는데 정해진 패턴이 있습니까? (한 곳에만 표시)
1.예 2. 아니오 99. 해당 사항 없음

21. 귀하께서 양로원으로 오신 후 그 분과 편지나 카드를 보냅니까?
(한 곳에만 표시)
1. 예 2. 아니오

22. 얼마나 자주 편지나 엽서를 보냅니까? (한 곳에만 표시)
1. 매일
2. 일주일에 1-3 번
3. 한 달에 1-2 번
4. 일년에 몇 번
5. 전혀 하지 않음

23. 귀하께서 편지나 엽서를 보내는데, 정해진 패턴이 있습니까?
(한 곳에만 표시)
1.예 2. 아니오 98. 잘모르겠음 99. 해당 사항 없음

다음 질문 사항은 "예" 또는 "아니오"로 대답해 주십시오. 관계에 있어서 다음과 같은 행동들이 있습니다. 귀하께서 양로원에 입주하신 후에, _____:

중요한 사람#1: 사회 지원의 기능 및 내용

24. 스킨쉽을 보여준 적이 있다
예=1 아니오=2

25. 귀하의 개인적인 감정에 대해 얘기하는 것을 경청한 적이 있다
예=1 아니오=2

26. 귀하에게 충고 (조언)을 해 준 적이 있다
예=1 아니오=2

27. 귀하에게 개인적이고/또는 현재의 일들에 대해 알려 준 적이 있다
예=1 아니오=2

28. 귀하가 인정 받은 느낌을 들게 한다
예=1 아니오=2

29. 귀하의 삶의 질에 관해서 칭찬을 한다
예=1 아니오=2

30. 귀하를 당황하게 하거나 고통을 준다
예=1 아니오=2

31. 쇼핑이나 세탁등의 개인적인 심부름을 한 적이 있다
예=1 아니오=2

32. 귀하의 개인 구좌를 관리하거나, 고지서를 계산한 적이 있다
예=1 아니오=2

33. 귀하를 슬프게 하거나 마음을 다치게 한 적이 있다
예=1 아니오=2

다음의 질문 사항들은 조금 복잡합니다.

중요한 사람#1: 지원 성향

34. 관계는 주고 받음을 의미합니다. 귀하는 _____의 관계에서 어떻다고 말할 수 있습니까? (한 곳에만 표시)
    1. 귀하가 그사람이 귀하게에 주는 것 보다 더 많이 준다.
    2. 그 사람이 귀하가 그 사람에게 주는 것 보다 더 많이 준다.
    3. 50 대 50 의 관계이다.
    4. 잘 모르겠다.

중요한 사람#1: 주관적인 평가

35. 귀하께서는 _____으로 부터 받는 지원이 많다거나/적다거나, 아니면 적당하다고 생각하십니까? (한 곳에만 표시)
    1.더 적다 2. 더 많다 3.적당하다 4. 잘 모름

36. 귀하께서는 그 사람으로부터 받고 있는 지원에 전반적으로 만족하십니까 아니면 불만족하십니까? (한 곳에만 표시)
    1.만족 2.불만족 3. 잘 모름

*****이제는 중요하다고 생각 하시는 사람#2 로 가서 지룸 #35 에서 #70 까지를 작성해 주십시오. 만약 중요한 사람 #2 가 없다면, 질문 #35-59 을 생략하시고 바로 #60 으로 가시면 됩니다.**

중요한 사람#2: 사회 관계

중요한 사람#2

37. 관계 (한 곳에만 표시)
    1) 남편 2) 아내 3) 아들 4) 딸 5) 사위 6) 며느리

    7) 손자/손녀 8) 자매 9) 형제 10) 조카 11)

    12) brother-in-law 13) 다른 친척들 14) 친구 15) 동료 거주자 16) 간호사

17) 사회 복지사 18) 시설 관리과 19) 다른 너싱홈 직원

20) 성직자 21) 자원 봉사자 22) 기타

38. 알고 지낸기간은 _____? (한 곳에만 표시)
1. 3-6 개월 미만
2. 6-12 개월
3. 1-2 년
4. 2-5 년
5. 5 년 이상

39. 너싱홈과 그 사람의 집과의 거리는 _____?
(한 곳에만 표시)
1. 25 마일 이상
2. 25 마일 미만
3. 같은 방
4. 같은 층

40. 귀하께서 양로원에 입주하신 이후로 그 사람은 방문을 합니까?
(한 곳에만 표시)
1. 예 2. 아니오

41. 얼마나 자주 방문을 합니까? (한 곳에만 표시)
1. 매일
2. 일주일에 1-3 번
3. 한달에 1-2 번
4. 일년에 몇 번
5. 방문 하지 않음

42. 그 사람이 방문을 하는데 정해진 패턴이 있습니까? (한 곳에만 표시)
1.예 2. 아니오 98. 잘 모르겠음 99. 해당 사항 없음

43. 귀하께서 양로원으로 오신 후 서로 전화 통화를 합니까? (한 곳에만 표시)
1.예 2. 아니오

44. 얼마나 자주 전화 통화를 합니까 _____? (한 곳에만 표시)
1. 매일
2. 일주일에 1-3 번
3. 한 달에 1-2 번
4. 일 년에 몇 번
5. 전혀 하지 않음

45. 귀하가 전화를 하는데 정해진 패턴이 있습니까? (한 곳에만 표시)
    1.예 2. 아니오 99. 해당 사항 없음

46. 귀하께서 양로원으로 오신 후 그 분과 편지나 카드를 보냅니까?
    (한 곳에만 표시)
    1.예 2. 아니오

47. 얼마나 자주 편지나 엽서를 보냅니까? (한 곳에만 표시)
    1. 매일
    2. 일주일에 1-3 번
    3. 한 달에 1-2 번
    4. 일년에 몇 번
    5. 전혀 하지 않음

48. 귀하께서 편지나 엽서를 보내는데, 정해진 패턴이 있습니까?
    (한 곳에만 표시)
    1.예 2. 아니오 98. 잘 모르겠음 99. 해당 사항 없음

다음 질문 사항은 "예" 또는 "아니오"로 대답해 주십시오. 관계에 있어서 다음과 같은 행동들이 있습니다. 귀하께서 양로원에 입주하신 후에, _____:

<u>중요한 사람#2: 사회 지원의 기능 및 내용</u>

49. 스킨쉽을 보여준 적이 있다
    예=1 아니오=2

50. 귀하의 개인적인 감정에 대해 얘기하는 것을 경청한 적이 있다
    예=1 아니오=2

51. 귀하에게 충고 (조언)을 해 준 적이 있다
    예=1 아니오=2

52. 귀하에게 개인적이고/또는 현재의 일들에 대해 알려 준 적이 있다
    예=1 아니오=2

53. 귀하가 인정 받은 느낌을 들게 한다
    예=1 아니오=2

54. 귀하의 삶의 질에 관해서 칭찬을 한다
예=1 아니오=2

55. 귀하를 당황하게 하거나 고통을 준다
예=1 아니오=2

56. 쇼핑이나 세탁등의 개인적인 심부름을 한 적이 있다
예=1 아니오=2

57. 귀하의 개인 구좌를 관리하거나, 고지서를 계산한 적이 있다
예=1 아니오=2

58. 귀하를 슬프게 하거나 마음을 다치게 한 적이 있다
예=1 아니오=2

다음의 질문 사항들은 조금 복잡합니다.

중요한 사람#2: 지원 성향

59. 관계는 주고 받음을 의미합니다. 귀하는 _____의 관계에서 어떻다고 말할 수 있습니까? (한 곳에만 표시)
1. 귀하가 그사람이 귀하게에 주는 것 보다 더 많이 준다.
2. 그 사람이 귀하가 그 사람에게 주는 것 보다 더 많이 준다.
3. 50 대 50 의 관계이다.
4. 잘 모르겠다.

중요한 사람#2: 주관적인 평가

60.귀하께서는 _____으로 부터 받는 지원이 많다거나/적다거나, 아니면 적당하다고 생각하십니까? (한 곳에만 표시)
1.더 적다 2. 더 많다 3.적당하다 4. 잘 모름

61. 귀하께서는 그 사람으로부터 받고 있는 지원에 전반적으로 만족하십니까 아니면 불만족하십니까? (한 곳에만 표시)
1.만족 2.불만족 3. 잘 모름

*****만약 중요한 사람 #2 가 없다면, 여기서부터 다시 시작하십시오.**

<u>통제력</u>

62. 귀하께서는 양로원에서 귀하의 삶에 대해서 충분한 통제 또는 충분하지 못한 통제를 하고 있다고 생각하십니까? (한 곳에만 표시)
1.충분한 통제 2.충분하지 못한 통제 3.잘 모름

<u>현재 귀하의 건강 상태</u>

63. 현재 귀하의 전반적인 건강이 어떻다고 생각하십니까? (한 곳에만 표시)
1.나쁘다 2.적당하다 3.좋다 4.뛰어나다

<u>지역에 살고 있는 자식들</u>

64. 생존한 자식이 있습니까? (한 곳에만 표시)
1.예 2.아니오

65. 몇 명입니까? (정확한 수를 적어 주십시오): _____

66-70. 어디에 살고 있습니까? (25 마일 거리 기준)

66. 자식 #1	1. 25 마일 이상	2. 25 마일 이하
67. 자식 #2	1. 25 마일 이상	2. 25 마일 이하
68. 자식 #3	1. 25 마일 이상	2. 25 마일 이하
69. 자식 #4	1.25 마일 이상	2.25 마일 이하
70. 자식#5	1. 25 마일 이상	2. 25 마일 이하

이 조사에 참여해 주셔서 진심으로 감사드립니다. 다음의 질문들은 인터뷰가끝난 후 작성하시면 됩니다.

71. 인터뷰 장소

1. 거주자 방 2.휴게실/TV 방 3.오락실 4.식당
5.사무실 6. 야외 공간 7. 복도 8 다른 장소

72. 인터뷰를 할 때 사생활이 보장이 되었나요?

1.예
2.아니오(설명:_____)

73. 마감 시간:_____

Appendix F

Tolerance Values for the Control Variables

Variable	Tolerance
Age	.81
Religion	.90
Years in current facility	.91
Number of diseases	.77
Number of activities	.39
Mean continence	.72
Focus on past roles	.51
Number of initiatives	.29
Telephone in room	.84

Appendix G

Tolerance Values for the Social Support Variables

Variable	Tolerance
Size of network	.16
Distance from facility	.60
Strength of network	.14
Frequency of support	.25
Affective support	.39
Informational support	.26
Appraisal support	.45
Instrumental support	.56
Negative emotions/behavior	.51
Perception of support	.23
Satisfaction with support person	.23
Perception of giving	.19
Perceptions of control	.49

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