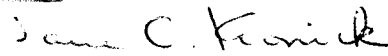


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I am submitting herewith a dissertation written by Ja-Won Kim entitled "Korean American Families' Care Behavior for Their Frail Parents." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Social Work.

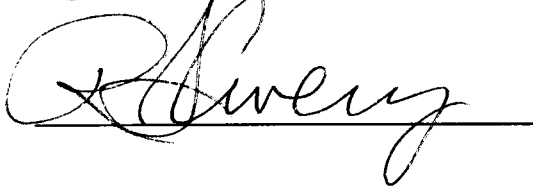


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KOREAN AMERICAN FAMILIES' CARE BEHAVIOR
FOR THEIR FRAIL PARENTS

A Dissertation
Presented for the
Doctor of Philosophy
The University of Tennessee, Knoxville

JA-WON KIM

August 1992

DEDICATION

This dissertation is dedicated to my parents,
Mr. Deuk-Moon Kim and Mrs. Bok-Ahm Won.

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ABSTRACT

The purpose of this study was to explore the relationships between sociodemographic variables (family income, length of residence in the U. S., working hours, availability of other family caregivers, and filial piety) and Korean American adult children's (or daughter-in-law's) care behavior for their frail parents. Care behavior included 8 care tasks; living arrangements, personal care, instrumental care, health care, emotional support, moral support, protective care, and financial support. The Burden Interview (Zarit et al., 1980) and Philadelphia Geriatric Morale Scale (Lawton, 1972) were used to assess caregiver burden and morale of the elderly. Ideologies of filial piety and the extended family were the framework of the care behavior.

A descriptive survey design involved non-random sampling and structured interviews with 36 dyads of adult children/daughters-in-law caregivers and their frail older relatives. The care behavior was based on the caregivers' responses to the degree of involvement in seven types of care activities and whether or not they lived with the older relatives.

Logistic and multiple regression analyses indicated that sociodemographic variables (except family income) affected 5 types of care behavior; living arrangements, instrumental care, health care, emotional support, and moral support. Caregivers who had alternative family caregivers were likely to provide a higher level of support in the five areas than the caregivers who did not have such helpers. Those who worked long hours and had lived long in the U. S. were less likely to provide emotional support and health care. Caregivers' filial piety was the predictor of their moral support to their older relatives while physical limitations explained variation in morale of the elderly and perceived caregiver burden. Canonical correlation analysis supported these findings.

Changes in care behavior pattern were observed; sons emerged as care-givers as daughters-in-law's involvement in care providing decreased. The majority of caregivers utilized formal support system.

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CHAPTER I

INTRODUCTION

1. STATEMENT OF THE PROBLEM

This study will explore caregiving behavior among the Korean population of New York City in families facing the increasing demands of a physically dependent elderly member. As a new immigrant population in the United States, the Korean frail elderly and the families responsible for their care are a population that is at risk. In order to plan effectively for needed services to this population, it is important to know more than we do about their situations and what support services would be most helpful.

Korean Americans are a rapidly growing cultural minority in the United States. There are about 800,000 Koreans in the United States, (U. S. Census, 1990). The elderly who are sixty years and over number 24,500 based on the estimation that 3% of the Koreans are the elderly. Most of the population has come to the United States since 1965. Many of the Korean families who care for frail elderly, therefore, may face multiple problems: in addition to the caregiving, they confront problems of adjustment to the culture of the main society. Korean tradition requires that adult children take care of their aged parents. The Korean immigrants' care behavior, however, may be affected by the major culture and situations of establishing a new life.

This study focuses on the adult children's care of their aged parents. While there is a growing literature describing family caregivers of elderly persons, there is a scarcity of information on how Korean adult children take care of their frail aged parents. Through

caregiving behavior, we examine how the traditional extended family system and the value of filial piety change among the Korean immigrants in New York city.

2. REVIEW OF THE LITERATURE

Ethnicity is viewed in two perspectives: Barth defines ethnic group based on genetics and cultural content (1969;10). The other perspective views ethnicity as a form of social structure that functions to achieve certain common ends (Gordon, 1964; Keyes 1981). The Korean American in this study fits in the first model in which biological perpetuation and strong family ties form the major cultural content. The cultural content may be affected by the situation created by immigration. The framework of family caregiving therefore is embedded in the "social norms and circumstances surrounding immigration" (Rosenthal 1986; 23).

This chapter provides a theoretical background on the concept of filial piety and the extended family as a care system for older persons in Korea. In the first section, a historical overview of the Koreans' immigration to the U. S. is presented. The second section will present how the ideologies of filial piety and extended family system govern the nature of caring for the older relatives in the family in Korea. Characteristics of the ideologies are described first followed by a discussion of how these ideologies are immersed in the social structure thereby facilitating the definition of family caregiving of the elderly in Korean society. The third section will present an overview of the family's care behavior in Korea and in the U. S. and finally the sociocultural factors which may be influencing the extended family system and care behavior will be discussed. The extended family in this study refers to the consecutive three generations within a household and the family relationship based on

socially prescribed roles, duties, and responsibilities rather than on personal feelings or affection.

Because the Korean American family's social adaptation in American society in this study is a process of acculturation, the process of acculturation will be discussed in the fourth section.

The literature review will provide a base from which hypotheses regarding the Korean families' care behaviors and their sociocultural contexts in the United States will be drawn.

A. Korean Immigrants in the U. S.

Ever since Koreans emmigrated to Hawaii in early 1900, the number of Korean immigrants in the U. S. has rapidly increased for the last twenty years to become the third largest immigrant group among Asians in the U. S. (World Daily News, 1991a). The 1990 U. S. Census reported that about 800,000 Korean residents are in the United States. In 1981, the number was 350,000 (U.S. Dept. of Commerce, 1981).

The characteristics of Korean immigrants are different depending on the period of immigration. Early Korean immigrants were single males and uneducated farmers (Hurh & Kim, 1984a). During the period of 1902-1905, about 7,226 Koreans emmigrated to Hawaii. The majority (6,048) were men, 637 women, and 541 children. Sixty-five percent of them were illiterate (Kim, 1974).

The Korean immigration to the U. S. resumed after the World War II. The immigration had stopped during Japan's occupation in Korea (Melendy, 1977; 129). The largest Korean immigrant groups during the period of 1950-1971 were young women whose age group was between 20-29 and female children under the age of 4. The former

were the wives of American military service men and the children were adopted by American families (Kim, 1974). During the period of 1950-1971, a total number of Korean immigrants were 57,129 and 17,679 non-immigrants became permanent residents.

The enactment of the Immigration Act of 1965 enabled the migration of Korean family members. According to the law, Korean skilled immigrants can bring their spouses and children. When they become American citizens after five years of residence in the U. S., they also can bring their parents and siblings' families for permanent residence in this country. Since the revision of the Immigration law, the number of Korean immigrants rapidly increased with about 30,000 coming to the U. S. annually. Many of them arrive in major cities, such as Los Angeles, New York, Chicago, San Francisco, and Washington D. C. In 1986, twenty-eight percent of the Korean immigrants arrived in California, 11 percent New York, 5 percent Illinois (World Daily News, 1991b).

The majority of Korean immigrants are self-employed. Although they are the most highly educated immigration group in the U. S., they can rarely find occupations compatible with their educational backgrounds because of language problems. The majority of them, therefore, engage in small businesses which are labor intensive (Min, 1990; Hurh & Kim, 1984 a). Korean immigrants' economic success has resulted from their long working hours (Min, 1990). Most often, wives work together with husbands or have another full time job to contribute to the family's financial resource.

Whereas the married people have come to the U. S. to have better economic opportunities, older parents have come here to unite their family as well as to support their children with housekeeping and child care (Min, 1984). The elderly's assistance is very important in the achievement of economic success in American society. Many Korean immigrant families in big cities, therefore, are composed of married couples and their children and, in many cases, their older parents (Min, 1984).

Although the older parents live with their adult children's family in the U. S., the extended household structure is different from the traditional one. In the traditional extended family system, the adult son brings his wife into the parents' household. However here in the U. S. the older parents move into their adult child's family. Because both the older parents and their children are exposed to different political and social views, changes in the traditional family system seem evident. Moreover modernization in Korean society may accelerate the Korean American's acculturation phase.

The Korean American adult children's support of their frail parents may vary depending on the level of acculturation and psychosocial resources. Through the children's care behavior, we attempt to analyze some changes in the ideology of the extended family system.

B. Ideologies of Extended Family and Filial Piety

The ideal Korean extended family refers to a series of nuclear families of male lineage living together on a vertical basis with economic and emotional interdependency. The duties and roles of the family members are prescribed by the values and traditions of the family.

The traditional extended family and filial piety have regulated Korean family life for centuries. The ideologies of the extended family and filial piety are rooted in Confucianism, the major emphasis of which is morality.

Since Korea adopted the Confucian doctrines as a formal morality in fifteenth century, they have been the principles of the society. Family life, especially, has been governed by Confucianism in terms of relation of the family members (Walraven, 1989). Confucianism is "a system of political and ethical philosophy advocating creation of a new,

orderly and harmonious society ruled by a gentle scholar" (MacDonald, 1988; 80). The family is the key element of the society. The family unit is a collective. Identity of individuals is found in their relationships and mutual obligations within their extended family and more importantly the relationships with their parents (MacDonald, 1988). This may be why one of the characteristics of the extended family system is strong ties between members of the family.

The most important relation in the family is the relation between parents and children. According to Confucianism, there are five Human Relations: Relations between father and son, ruler and subject, man and wife, older and younger brothers, and between friends. Of the five relations, the relation between father and son is most important. The relationship between a child and parents is permanent: Everyone must be obedient to his parents, take care of them with a full warm heart, and respect them even after their death through rituals of ancestor worship .

The relationship between father and son has been governed by the virtue of filial piety. To respect filial piety is to follow the "Mandate of Heaven and therefore, reach the union of Heaven and man" (Kim, 1989). According to the Confucian philosophy, a man becomes humane by practising benevolence: filial piety and brotherly love are the basis for implementing benevolence (Choe, 1984).

Filial behavior has two major components. One is to reward one's parents from whom the individual has received life. It is his/her duty to reward the origin of his/her life, body and spirit. The other component is the repayment of the affections and favors that parents have provided their children. Because the parents devoted themselves to their children, it is right for the children to care for the parents in return. Loyalty, respect, and devotion are the main themes of filial behavior (Li, 1987). Filial behavior thus necessitates the extended family structure in which adult children serve their parents.

Confucianism was a social and political tool throughout the Yi dynasty (1392-1910). Embraced by the higher social class, Confucian values were transferred to the citizens of all walks through education and family rituals and corresponding institutional development (Haboush, 1988; Joe, 1982). The main teaching of the village school for young children was the relationship between parents and children (Walraven, 1989). Low class citizens were forced to practice rituals for ancestor worship which had been the privilege of high social class (Ro, 1989). The government also collected stories about filial conduct to reward and publish. Finally "family structure was reorganized to patrilineal unit. The uxori-local marriages of the Koryor (prior to Yi Dynasty) became patrilineal units. The mourning and ancestral rites were assumed by a patrilineal line of family unit" (Haboush, 1988;13). The state was seen as an extension of one's family; "proper relationship between father and son became the paradigm for all hierarchical relationships in a moral society (Janelli & Janelle, 1982; 50)."

Common among the stories of virtuous conduct is that miracles occur by ferocious filial behavior. The following is one of the stories in *The Examples of the Virtues of the Five Human Relations* published in 1797. A young man stays beside the tomb of his father day and night. One stormy day, an incense burner which is used for worship at the grave disappears. Several months later, a crow brings back the burner for it has been moved by the man's filial behavior (from Walraven, 1989; 8).

Although the level and forms of practicing of filial piety have changed, influenced by western culture and modernization, the basic meanings and functions of the value are challenged little in modern Korean society (Brandt, 1971; MacDonald, 1988; Sung, 1990). 'Social emphasis of filial piety' (Sung 1990; 610) and lack of formal social support for the elderly exemplify how the attachment to the traditional values persists in the society.

Social campaigns such as "Filial Piety Prize system" and "A week for the Respect for the Elderly"(Sung 1990; 610) are annual social events. The government provides prizes to the adult children or children-in-law who have cared for their parents or parents-in-law with great sacrifice. Family caregivers throughout the country apply for the prize and their caregiving behaviors are screened by the committee members. During "A Week for respecting for Elderly", various public activities are provided to promote the public spirit of respect for older people. Usually the mass media report in a special edition on topics of aged people and catch-phrases of respect for elderly are posted in public places during the week.

The role of the extended family as the main care system for the elderly is ensured by legal provisions. It is only in recent years that the government recognized its responsibility for the group. Under the legislation enacted in 1981, elderly persons sixty-five and older are given special discounts when they use public facilities such as buses and trains. The law promotes "the maintenance and development of a family system based on high morals such as filial piety and respect for elders" (Yonhap New, 1988; 201). After 1987, state employees who live with their aged parents receive a financial support (about \$20.00 per a parent per month). The government also provides a limited income tax deduction to adult children who have lived with their older parents more than five years. The public service benefits, however are so small and marginal that most families' responsibilities for their aged member are affected little by these benefits.

Confronted with modernization and western influence, Confucianism has declined in modern society (Keum, 1989). However it still affects many aspects of the family life. According to a recent national census (Lee & Kwon, 1989), eighty-four percent of the population aged sixty and over live with their immediate family members. Fifty-two percent of the elderly live in more than the three generation household and about twenty-five percent

of the respondents live in the second generation household where the elderly live with their single children. Thirteen percent of the aged live with their spouse only. Fewer than ten percent of the elderly live alone. Although the proportion of old people living in separate households is increasing, the pace of the change is very slow. The proportion of the elderly who live alone or live with their spouses increased less than one percent and 1.6 percent respectively since 1985 (Korean Institute for Population & Health, 1985).

The social attitude toward filial obligation persists across the population. Many families observe family rituals and customs such as ancestor worship and having one of the sons' living with his parents (Brandt, 1971; Moon, 1974; Shapiro, 1988). A survey of college students reported that 94% of them thought it necessary for the adult children to support their aged parents (Heo, 1988). About 70% of the students reported that they wanted to live with their older parents after marriage. Another study on the pattern of selection of folk tales for children (Chung et al., 1972) reported that 47 percent of the women respondents preferred stories of feeding and caring for aged parents to stories about scientists (42 %) or interesting fairy tales (11 %).

Sung (1990) analyzed 817 stories of the family members' filial practices and found that the motives for caring for their elderly members were the respect for the parents, filial responsibility, harmonizing the family and filial sacrifice. The sacrifices of the family were made in the form of physical labor, paying for medicine, and losing a normal social life. Because most of the elderly in the study were impaired, physical sacrifice ranked first in terms of the extent of sacrifice. Care providers spent much time on personal care such as bedside nursing, care for incontinence, preparing and serving meals and medicine, laundry work, and bathing. The study interpreted the findings as "by putting their household in good order, the filial persons cared for their parents with respect and responsibility while making sacrifices for their parent" (Sung, 1990; 615). The caregivers in the study may not

represent the general population. However, the study shows that family caregiving represents the family's efforts to facilitate social norms. The ideal extended family and filial obligation is a tradition and reality.

Care of the Elderly in Korea

The extended family is the major care system for elderly persons in Korea. A vast majority of aged people live in the same household as their adult children (Im et al., 1985), and a large proportion of the elderly are taken care of by their children until they die.

A female family member who lives with an elderly person becomes a primary caregiver. The traditional Korean family is a patriarchal system. A son brings his wife to his parents' house and the extended family continues generation after generation by the male lineage. Traditionally a woman is confined to the home and responsible for household chores. The adult son's wife or mother has the responsibility for care for relatives. For centuries, one of the major duties of a married woman has been to respect her parents-in-law (Brandt, 1971). Males provide instrumental and financial supports. It is not common for a married daughter to live with her parents because she joins her husband's family at marriage. However, the daughter provides care to her parents in the form of visits, emotional and financial supports. Primary caregivers receive assistance from female relatives, friends or neighbors when needed.

This arrangement is possible because currently many housewives are not employed (Im et al., 1985). Care behavior therefore, is embedded in the family structure and history rather than in the emotional relationship between the caregiver and care receiver.

Caring for aged parents becomes a part of a family's daily living. Onset of an illness or disability has little effect on the nature of family care. Upon discharge from a hospital,

the elderly go back where they used to live. The severity of their physical or mental conditions rarely changes the living arrangement of the elderly.

Some of the motivators of family caregiving may be explained by social norms. Social obligation may be a strong motivator. Society identifies the elderly population as a group who suffered to raise a new generation and who deserve to be cared for by those whom they have raised (Sung, 1990). An indicator of socially obligatory behavior is the daughter-in-law's caregiver role. It is socially designated rather than chosen by her. A great majority of the daughters-in-law support their parents-in-law because they are the wives of the eldest sons (Im et al., 1985). Lack of a formal support system ensures the social obligation of the family in caring for the elderly.

Reciprocal relations between child and parent may be another factor affecting family care behavior. Traditionally the eldest son inherits most of the family property and assumes responsibility as the head of the family. In turn, he is required to support his aged parents until death. It is common that the first son's family lives with his parents (Im et al., 1985).

Proximity is also affected by the norm of patriarchal extended family. If the elder son fails to live with his parents due to geographic distance, another son assumes the responsibility. In a survey study (Im et al., 1985), about 50% of the aged people lived with their son's family whereas only 2% of them lived with their daughter's family.

Personal factors such as affection and attachment may be a strong factor; family caregivers have lived with the elderly most of their lives so a strong attachment may have been established between them. However, the impact of social norms will be great in shaping the pattern of care behavior.

The elderly persons who do not have a family and are poor may be admitted to the public adult homes which are scarce throughout the country. There are a few private

nursing homes for the deprived frail elderly. Many nursing homes are operated by church groups and are charity-oriented. The total number of the residential facilities for the elderly in Korea was 82 with 5,870 aged people in them in 1989. The number of residents is less than 0.3 % of the elderly population (Kim, 1990). Industrialization and urbanization, thus, have had little impact on the function of the extended family even though the form of the family is changing to the nuclear one.

When the adult children's family live with their older parents, it is most often assumed that the family provides every possible service to the elderly from personal care to paying the elderly's medical insurance. A study reported that more than a third of the elderly subjects received support with activities of daily living from their daughters-in-law, 18% from sons, 13% spouses, 5% daughters, and 25% from others (Im et al., 1985).

The major income source of the elderly is their children. According to a survey study (Department of Economic Planning, 1987), 60% of the elderly reported their income source was their children; 37% of the subjects reported their first son as the provider of the financial support, 23% other children. Those who had income from their job were 23% of the subjects and about 8% reported the income source as pension or insurance. Some of the jobs the elderly have, however do not provide enough income so that they need to depend on their children for financial support (Lee et al., 1989).

The Korean family also pays for the older relative's health care for there are few public medical programs for aged people (Lee et al., 1989). In the study on elderly, about 48% of the elderly were medically insured through their adult children. If older parents have proof of living with their child, they are qualified to be included in the claims of the child's job medical insurance. Those who cannot have the insurance need to pay more for their medical care unless they are extremely poor and qualified for free health services.

In summary, the extended family system is the mode of family organization in Korea. In this family system, three consecutive generations share a household with economic and emotional interdependency and the family roles and duties are socially prescribed. Caring for the older relatives in the family is a norm.

Korean Family Care of the Elderly in the United States

Little is known about how the traditional values and the changes in family structure affect family care behavior among Korean families in the United States. The impact of any changes will be great on the frail elderly as their dependency on the family increases. Expansion of women's role in the labor market, the younger generation's preference for a nuclear family, and the reduction of the size of the natural support networks are some of the factors limiting the ability to provide traditional family care. Who the substitutes of the family caregivers are, where the elderly persons are living, what types of care are provided, and what role the value of filial piety has in the family caregiving situation will be important questions to be answered.

Studies of Korean American elderly report the mutual relationship between the adult children and their elderly parents. We know little about how the relationship changes as the parents' dependency increase and the reciprocal relationship no longer exists. Koh (1983) reported that about 30% of the elderly respondents indicated that they would turn to the formal social service system when they need help. Korean aged people also do not seem to rely on their adult children much for the source of emotional support. Park (1986) noted only 39% of the Korean American elderly identified the family as the primary source of companionship when feeling lonely although about 80% of them indicated the family was the source of help for instrumental services. The findings may imply that elderly persons

realize the limits of their adult children's helping ability. Examining the factors influencing the relationship between older parents and their children may be a first step to understanding Korean American caregivers and their elderly.

The Korean elderly have lost much of their intimate social ties due to immigration and they continue to suffer from the lack of social ties in American society. Despite a high level of elderly coresidence with their family, many of them report problems of loneliness, isolation, and feelings of insecurity (Kiefer et al, 1985). A study on nine ethnic elderly groups in America (Weeks, 1984) also reported that nine out of ten Korean American elderly lived with their children; however, the same respondents were the least satisfied with their lives among the nine ethnic groups. Given this information, we assume that family and the elderly both suffer in the transitional period of immigration to another country.

How are the American frail elderly taken care of?

In America, the Parsonian (Parsons, 1943) concept of conjugal family life has been most influential since World War II. A major family function is to socialize children. In the process of socialization in the family, children obtain values and skills to meet occupational demands and to serve the industrial society. In the conjugal family form, the relations with elderly parents and other kin members are not included. Despite the challenge of the diverse family forms in modern American society, the conjugal family still is viewed as an ideal family model.

The elderly's relation with their adult children has been conceptualized in the area of kin networks or 'modified' extended family (Litwak, 1960). Many families retain the extended family bond. The elderly live near their adult children having a mutual relationship

and frequent contacts. The kin network or modified extended family relation is described as two separate nuclear families bound together on the value of egalitarianism.

The frail elderly are taken care of by their family members (Shanas, 1979; Brody, 1985) and formal social systems (Shanas & Sussman, 1977). Family caregivers are decided by 'the principle of substitution' (Shanas, 1979). The primary caregiver is usually a spouse. If the spouse is not available, an adult child becomes a primary caregiver (Horowitz, 1985; Stoller, 1983). If both are not available, another relative takes the care responsibility. Adult children caregivers visit or call to support their older relatives. Some parents move in with their children. However, this arrangement is not considered permanent.

Adult children support their aged parents voluntarily (Streib & Shanas, 1965). The supporting behavior is not a societal or family norm. 'The common belief that older people live alone and are neglected by their offspring and other kin' (Shanas, 1979) may be related to the absence of the norm of filial care.

Adult children's gender, geographical proximity, and relationships with the care receiver are identified as factors associated with the level and types of their care behavior (Horowitz, 1985; Stoller, 1983). Daughters tend to provide the hands-on services and sons instrumental care such as transportation. Many of the adult children caregivers live close to their parents. The majority of caregivers are daughters of the aged people. The provision of services includes physical care, providing shelter, transportation, housekeeping, shopping and emotional support. (Horowitz, 1985). When the caregivers exhaust their physical and emotional resources, ailing older persons are placed in institutions.

The state assumes part of the responsibility for older people by financing the social security system, medical insurance programs, private pensions, and other programs (Shanas & Sussman, 1977). Financial support is provided to an individual older person. In a

review of the literature on elderly dependence, Evans & Williamson (1988) point out that the nuclear family system existed throughout preindustrial England and contributed to the need for outdoor relief programs and institutions for frail older persons. Although the family is recognized as a major source of support for frail elderly people in American society, the adult children's commitment to filial care is not culturally supported. This may be because the 'intergenerational relationship in later life is not clearly defined' (Mancini, 1989) in a nuclear family system and a formal support system has been available for frail elderly persons.

In the Korean extended family system, the adult children's marriage and the birth of grand children is an important family extension stage in terms of 'family development' (Duvall, 1949). The older parent's roles are expanded at this stage as they are expected to guide the family life by its tradition. The older parents' following their children's family to another country and their active support to the offspring obviously is an effort to maintain the extended family and kinship.

C. Acculturation

Studying an ethnic group concerns its relations with the major society. In the social process, the cultural elements of the ethnic group change affected by the culture of the major society. The cultural change is called 'acculturation' or 'cultural assimilation'. Acculturation in this study is based on the definition formulated by Redfield, Linton, and Herskovitz (1936); "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first hand contact, with subsequent changes in the original cultural patterns of either or both groups" (p.149).

The processes of acculturation are complex and dynamic. The acculturation takes place through the transmission of cultural elements such as objects, traits, or ideas (Broom et al. 1967; 271). External cultural elements of clothes, language, and behaviors are easily adopted. Internal elements such as attitude and belief systems however, resist change for generations (Mead, 1975).

Particularly, ethnic values and dispositions seem to be persistent. Studies on Asian and Jewish immigrants report that despite the high level of acculturation in the U. S., their ethnic attachment has not declined (Zenner, 1988; Hurh & Kim, 1984b). Hurh and his associate noted that ethnic attachment was not affected by the length of residence in the U. S., socioeconomic status, and social and cultural assimilation rates. Lee (1975) noted that interracial marriage did not break the ethnic boundary among Korean Americans.

The major cultural elements often are incorporated into the native culture to be reorganized or reshaped (Broom et al., 1967). Eaton conceptualized 'controlled acculturation' as "the process by which one culture accepts a practice from another, but integrates the new practice into its own existing value system (Eaton, 1952; 338). The ethnic culture, therefore may differ from the culture of the native society.

There are two conflicting views about the acculturation of the Asian family values in the United States. Some studies report that family structure and relations change as a result of direct contact with the dominant culture (Embree, 1941; Kitano, 1969). Other studies argue that Asian families still maintain the value of extended family even after several generations (Connor, 1974). Various forms of acculturation may occur depending on the characteristics of the immigrant group. An acculturation process seems inevitable in the areas of the family system especially when the traditional value is not a norm in the main society.

Changes in the values of Asian immigrant families of the North America have been observed in studies. In a study on Japanese farmers in Hawaii, Embree (1941) described the process of changes in the family system social networks. In the study, the second generation's rapid acculturation influenced the family relations; family solidarity and the power of a father was weakened by the ideology of individualism. The extended family system changed to a nuclear one. The Japanese neighbors, friends or those who had been from the same region of Japan were substituted for kin.

Kitano (1969) noted that the third generation of Japanese Americans was completely identical to the Caucasian group in terms of achievement, interest preferences, and social values (p.142). The early Japanese American families retained the Japanese pattern in being interdependent with larger neighborhood and community unit. However egoistic behavior and the importance of self over others have developed among the third generation. The Japanese immigrants' problem solving mechanisms slowly changed from family members to the community and then to professionals. Although the phase of acculturation was slow among the second generation, the direction was toward the American norms.

Other studies on Asian immigrants report that adoption of some aspects of American culture does not necessarily lead the ethnic group to replace their own culture with the major one. Particularly, family systems and values have been sustained after several generations despite the extensive acculturation (Connor, 1974).

Connor(1974) reported that the third generation of Japanese Americans have closer family ties, a greater sense of duty and obligation than do the Caucasian students. In the study, the second generation's common response to the question of what Japanese cultural traits they would like to see retained was "respect for parents, elders, and authority."

Hsu (1971) noted the young generation of Chinese Americans rapidly adopted the value of freedom; however the bond between their parents was closer than the bond between the white younger generation and their parents.

Because of the short immigration history, there are few studies on acculturation of Korean American immigrants. In a study of first generation Korean Americans in Los Angeles, (Hurh and Kim, 1984a) most respondents reported that family duty was more important than were individual interests. The traditional gender roles persisted; the wives felt obliged to do the household tasks although a great majority of them were employed (p. 163).

As Redfield and associates (1936) noted "acculturation is distinguished from culture-change, of which acculturation is one aspect, and assimilation, which is at times a phase of acculturation(p.149)." Family values particularly appear resistant to change.

The situation or factors affecting the acculturation of the Asian immigrants in American society included the length of residence, geographic areas of settlement, compatible values, and aspiration for success. A slow acculturation process was observed among the first generation of Korean immigrants (Hurh & Kim, 1984a). Many Koreans experienced difficulty with English and they tended to associate with the Korean community. Connor (1974) noted that, as the generation of Japanese American went up, the number in the household was reduced. Caudill (1952) reported the rapid adjustment of the first and second generations of Japanese Americans in the Chicago area after World War II was due to the compatibility of the values of the Japanese American and the American middle class. Similarly, practicality and aspiration for success were suggested factors contributing to Japanese immigrants assimilation to the American middle class (Kitano, 1969).

Economic survival has been reported as a factor affecting acculturation during the early stage of immigration (Steinberg, 1981: 53). Many immigrant groups come to the U. S. for economic opportunity and find hard labor to be the ladder of economic success. All possible family resources are utilized to establish a stable living. The force of pragmatism may be extended to the traditional family system if the system is not functional for economic achievement.

The contexts of acculturation are favorable for Korean immigrants. The family system undergoes change influenced by modernization and the western value of egalitarianism in Korean society. Many Koreans entered the U. S. when American society began to recognize 'cultural pluralism' (Gordon, 1964) and the civil rights of ethnic minority groups. The circumstances and economic aspiration may accelerate the acculturation of the Korean American family.

Social norms and situations of immigration both will shape Korean family life. The central theme of this study is to determine how the family structure and relations will change and what factors determine the family care behavior for the older relatives in the process of adjustment to the new environment.

Data on Korean Americans suggest that the Korean family system is changing toward the adoption of western culture. Korean immigrants seem to be in the middle of a transition from the traditional extended family system to a modified nuclear family system. The number of Korean elderly who live in separate households is increasing. However, extended family ties are supported by the close relationships between elderly persons and their children which are maintained by the nuclear family. Instead of living together, the adult children provide care in the form of visits, telephone calls and material supports (Koh, 1983; Park, 1986).

Factors affecting the family support of older relatives include the history of family relations, the working hours of the caregiver, the size of household, and the living arrangement. Sussman (1965) found a relationship between the elderly's involvement in kin networks prior to illness and the care they receive. Koh (1983) reports that Korean American adult children are likely to assume some part of the responsibility for their parents when they are ill because the elderly and adult children are involved in close relationships of mutual help.

Other studies of Korean elderly, however, report the family does not spend enough time with their older relatives and there are problems of isolation from their families and from society. Many elderly are confined to home, having little social interaction because of lack of mobility and language skills. They are entirely dependent on their adult children for companionship with kin or friends (Min, 1984; Kiefer et al., 1985). Such companionship is limited by the long hours of work of adult children and their spouses.

The reduction in size of kin networks may contribute to the decrease in the Korean American elderly's involvement in the family and social activities which results in the increase in the amount of time the elderly are alone. The elderly are also isolated from the second generation because of cultural differences. Weeks (1984) reports that although the level of the Korean elderly's co-residence with adult children was high, the level of their life satisfaction was the lowest among the nine ethnic groups. Park (1986) reported that Korean elderly in New York city did not rely on their adult children for companionship as much as they did for instrumental services. The findings make us assume that the value of filial piety may not be actualized in caregiving situations as much as the elderly expect.

Adult children's living with their aged parents has been regarded as fulfilling a family responsibility in Korean society. Especially when their parents are ill, they are

obligated to care for the parents at home. Studies support the relationship between the provision of care the elderly receive and their living arrangements. In a study on the Korean elderly in New York City, Koh (1983) found that elderly persons who live with family members were more likely to receive health care services from their children during the illness. In this study, when they did not live together, the geographic proximity of the children and the frequency of contacts were not related to the provision of health care from adult children.

The social norm of filial responsibility and strong family ties certainly will guide the Korean American family's care behavior; however, it can be an additional stressor to them. The structured inequality of the society and confrontation with different norms and values may generate emotional strain. Aldwin and Greenburger (1987) reported that Korean American college students' depression scores were higher than Caucasians'. The major factor of the depression was related to their strong value orientation. The Korean family instills the value of achievement and loyalty in children.

Another aspect of caregiving behavior is the adult children's attitude toward the dependency of their aged parents. Studies suggest that although feelings of affection and obligation toward elderly parents may lead to increased helping, extended dependency of aged parents create negative feelings in the children. A number of studies report the positive association between caring for a chronically ill elderly family member and caregiver burden and deterioration of the relationship between adult children and their aged parents (Chenoweth & Spencer, 1986). Exchange theory is often adopted in describing the relations between adult child and parent. According to the theory, both contribute something to the relationship. The pattern of mutual aid is broken when the parents' dependency increases. This situation generally creates negative feelings in both generations.

In Korean society, the concept of interdependency between parent and child is more than the give and take of relations but represents an organic tie, a basic reward of human relationship. Exchange of material and emotional supports certainly helps to strengthen the positive relations between the parent and child. However, dependency is accepted as an inevitable human condition among family members. When the dependency of the elderly parents on adult children is socially accepted, the level of the caregiver's emotional reactions may not be as severe as that faced by the American caregivers.

3. DEVELOPMENT OF HYPOTHESES

The Korean family's caregiving to their aged member appears to be associated with sociocultural contexts rather than the commitment to filial responsibility, *per se*. Because the Korean immigration history is short, many Korean families experience problems with lack of housing space, time, financial and natural support resources. Accommodating a separate room for an aged parent is expensive in a large city like New York. Unlike family attitudes in Korea, the second generation may not want to share their room with grandparents. A large proportion of the daughters and daughters-in-law of the aged persons are in the labor force for economic reasons. Wide family networks often are not available here in the U. S. The magnitude or level of family care, therefore, may be related to the family resources more than to the level of their devotion to the aged person.

Korean families who have lived in the U. S. longer may have become stabilized and adjusted to the larger society more than the recent immigrant families. Their life style may have changed to a nuclear family pattern. Their responsibility may be primarily towards their own nuclear family members rather than extended family members. In comparison to more recent immigrants, the families may feel less strain in using paid-

caregivers and community programs. We can hypothesize that there is a relationship between the length of time the family has lived in the United States, family income and care behavior.

Many Korean immigrants engage in small business which requires long hours of labor and thereby they may be unable to spend much time with their parents. Reports of the Korean elderly's feelings of insecurity, isolation, and loneliness (Weeks, 1984; Kiefer et al., 1985) may be interpreted in part as dissatisfaction with the amount of time the family spends with them. When the elderly require extended care, the family is likely to spend a great deal of time with them. The family's care time, however, may be spent on meeting the basic or physical needs of the elderly persons more than on the socioemotional or moral support due to the limited time and energy. Working hours, therefore, will be related to the type of care behavior.

The reason for the Korean elderly's immigration to the United States is to unite their family (Min, 1984) so that they must be attached to the meaning of the traditional extended family. The key element of the value of the filial piety is to respect the aged parents. The family pays respect to the elderly person's life experience, wisdom, and views on life in general. The adult children ask for the parent's advice on family matters and assure them they are counted on. In daily living, the family expresses to them respect by serving them first at meals and other social occasions which require social manners.

Socioemotional support such as the expression of family concerns for the well-being of the elderly, listening to and talking to them, and being with them when they are depressed may be some of the behaviors which may enhance their morale. The type of care behavior may be associated with the morale of the care receivers.

The dependency of the elderly may also be related to the level of strain the family experience. Studies suggest that although feelings of affection and obligation toward

elderly parents may lead to increased helping behavior, extended dependency of aged parents creates negative feelings on the part of the children (Cicirelli, 1981; Brody, 1985; George & Gwyther, 1986). A number of studies report an association between caring for a chronically ill elderly family member and the loss of social life, and emotional problems among the caregivers (Brody, 1985; Cantor, 1983; Deimling & Bass, 1986; George & Gwyther, 1986). The private lives of the family members and health of the primary caregiver are affected by the caregiving.

The Korean family has a tradition of strong kinship ties which is reflected in their life in the United States. Many Koreans have immigrated to the U. S. at the invitation of their siblings. If the family has more than one adult child who shares the care responsibility (Matthews & Rosner, 1988), the family may experience less strain from the caregiving situation. A relationship between family support and caregiver's emotional state has been found in studies (Zarit, Reever, & Bach-Peterson, 1980). We do not know whether the social support affects the level of care behavior and strains among the Korean families. The availability of other family caregivers may be related to the level and type of care behavior and caregiving strain.

4. OBJECTIVES OF THE STUDY

The general objective of this study is to determine the relationships between the characteristics of the caregivers and care receivers, and care behaviors and burden of the caregivers and morale of the care receivers. One of the specific objectives of this study is to examine the relationship between the family caregivers' length of the residence in the United States and filial piety and their care behavior. A secondary objective is to find out

how the caregivers feel about the caregiving situation. A third objective is to find out the relationship between care behavior and the elderly care recipients' morale.

Specific objectives are

1. To identify and describe certain demographic and personal characteristics of adult children/children-in-law of the care receiver.
2. To identify and describe certain demographic and personal characteristics of the frail parents of the adult children/children-in-law caregivers.
3. To identify and describe types and level of care behavior of adult children/ children-in-law to their aged parent.
4. To determine the relationships between the characteristics of the caregivers and care receivers, the caregiver-care receiver relationships, and the adult children's care behavior (living arrangement of care receiver, level and types of care behavior of adult children or children-in-law).
5. To determine the relationships between the caregivers' filial piety, length of residence in the United States, income, employment status, and presence of other caregivers and their care behavior.
6. To determine the relationship between the disability of the care receivers, filial piety of caregivers, and caregiver's perceived burden.
7. To determine the relationships between the level of disability of care receiver, care behavior, and morale of the care receiver.

The following are the research questions addressed by the study.

1. To what extent is the extended family system maintained among Korean American families who provide care to their frail parents in New York city?

a. Is there a relationship between the length of the adult children caregivers' residence in the United States, family income, employment status, and availability of other family caregivers and the adult children's care behavior (living arrangements of older parents and 7 types of care behavior)?

b. How does the caregivers' filial piety compare with sociodemographic variables (the family income, length of residence in the U. S., employment status, availability of other family caregivers) in terms of impact on the type of care behavior?

2. Is the caregivers' length of residence in the U. S. associated with the utilization of outside help in caring for their frail parents?

3. To what extent will the characteristics of care receivers (disability, living arrangements, gender, marital status, relation to caregiver, whether they have health insurance or not) and relationship between caregiver and care receivers be associated with caregiver burden?

4. To what extent are the characteristics of caregivers (employment status, having children under 12 years of old, health, availability of other family caregiver, and filial piety) related to caregiver burden?

5. Is caregivers' family income and length of residence in the United States related to family strain?

6. How does the type of care behavior compare with the level of disability of care receivers in terms of impact on care receivers' morale?

5. DEFINITIONS

Care behavior means the behaviors practiced by the Korean family in taking care of its frail elderly member. The care behaviors are provided to assist, rehabilitate the physical functioning of the elderly as well as to support or enhance their emotional state.

Frail elderly person for this study are defined as native Koreans who are 60 and older and immigrated to the United States and live in New York city. They must experience problems with at least one activity of daily living such as eating, grooming, bathing or in activity of daily living such as house cleaning, cooking, and outings.

Caregivers refer to the kin members who provide major care for his/her aged relative among the elderly's children/children-in-law. The caregiver is identified by the elderly care recipient.

The dependency of the elderly will be measured by the scores on Activity of Daily Living, Instrumental Activity of Daily Living (Lawton & Brody, 1969), and symptoms of mental impairment (Poulshock & Deiming, 1984), and the level of financial status of the elderly person.

Family care behavior includes the living arrangement of the frail elderly, the level of family care tasks, and the level of the use of informal and formal services. The care tasks are divided into three groups by the level of personal contact and time spent. The three division concept is from the work of Cicirelli (1983). Because of the nature of the population, we add health and cultural aspects to the concept.

The primary group includes Personal, Instrumental, and Health Care. Personal care includes assistance with moving in and out of bed/chair, eating, dressing, grooming, bathing, toileting. Instrumental care includes laundry, house cleaning, meal preparation,

house maintenance, groceries, shopping, and transportation. Health care includes calling physicians at the elderly's request or when symptoms are shown, assistance with taking medication, knowledge about the side effects of the medicine, maintaining the safety of the residence (e.g. any obstacles for causing falls on the stairs, floors, kitchen, or bathroom) and nutritional diet. Secondary Care includes Socioemotional care, Moral supports, and Protection. Socioemotional care includes bringing reading or recreational materials or gifts, taking the elderly to social gatherings and church, having the elderly participate in the family gathering or outings, spending extra time to talk to and listen to the elderly, being with the elderly when they do not feel good. Moral support implies respecting the elderly member's life experience, asking for advice regarding family and other social matters, serving the elderly first at meals and showing respect on other social occasions, having the second generation interact with the elderly, maintaining the relationships with kin, considering the elderly's preferences when preparing meals and/or shopping the items for them. Protection care includes managing financial and legal matters of the elderly, mediating and facilitating public or private care services such as social services and hospitals.

The third dimension of the care behavior is the Financial Support. The tasks include paying for the medical care, housing, utilities, groceries, clothing and other personal items, care services, and providing with pocket money.

Caregiver variables include sex, marital status, age, work status, familial relation to the care receiver, health, motivation for caregiving, and psychological relationship with care receiver (feelings of closeness to the care receiver).

Family variables include family income, the length of residence in the United States (If the adult children and their spouses have come to the U. S. at different time, the years of

the male caregiver's residence are used), use of informal and formal services, availability of another family caregiver, caregiving strain, and religion.

Korean immigrants tend to have low status occupations which are not equivalent to their educational background because of language and other sociocultural barriers. Therefore, their family income needs be weighted independently to the overall social status. Family strain means the caregivers' perception of pressure or tension and constraints in family and social life because of the dependency of their older family member. The areas which may be affected by the dependency of the elderly include management of housekeeping, relationship among family members, family social life, personal life of the family members, job performance.

Caregiver burden is defined as emotional, physical and financial strains caregivers experience because of caregiving to the frail elderly. The Burden Interview (Zarit, Reever, & Bach-Peterson, 1980) measures the levels of effect of caring in the three areas as well as the caregivers' relationship with care receivers. Although the 22-item scale is designed for caregivers of demented aged patients, it has been useful to measure the adverse effect of caregiving to non-demented patients (see Stone, 1987). The scale is treated as a unitary score, however the dimensions of subjective burden of caregivers can be explored. The status of the elderly will be measured by their sex, age, marital status, living arrangement, the level of disability, the length of residence in the U. S., financial resources, whether holding a medical insurance policy or not, and religion.

" Filial piety is defined as an individual's beliefs about one's duty and responsibilities regarding his/her aged parents/parents-in-law. The individual's attitude toward the responsibilities is represented by his/her beliefs about how much he/she would accommodate the central themes of the filial piety; loyalty, respect, and devotion. Ho & Lee (1974) operationalized the concept of filial piety in 22 items. It has been administered

to Chinese adult children and elderly persons. The split half reliability coefficient was .81. Because the Korean's concept and practice of filial piety are similar to the Chinese, the scale seems suitable to the population of this study. For the purpose of this study, two items will be rephrased in less restricted and more realistic terms.

Morale of the care receiver refers to the Korean American elderly's feelings of loneliness, sense of belongingness, and attitude toward aging and life situation in general. While being socially active is considered as a successful or desirable way of living in the western society (Cumming & Henry, 1961), having a good family relationship is a very important aspect of the elderly's life in Korean society. The family relationship of the elderly reflects their status and meaning in the family. Family caregiving, therefore, can be the major life arena where many frail elderly persons experience aging. Lawton (1972)'s morale scale will be used for this study, for it is designed to assess multidimensional aspects of aging including social relationships.

CHAPTER II

METHODOLOGY

This study is multifaceted and focuses on describing selected characteristics of two particular groups. This study is a cross sectional survey of adult children/daughters-in-law caregivers and their elderly care receivers, and determining the strength of association between variables.

1. STUDY SITE

The study samples were drawn from the Korean elderly residents in the New York city area. In New York city, the elderly population of those who are 60 and older was about 1.8 million in 1990. The number accounts for about forty percent of the elderly in the state of New York and five percent of the elderly population in the United States. Although the general population has decreased in the city, the elderly population has increased from 13.5 percent of the total population in 1980 to 24.6 percent in 1990. About 14 percent of those 65 years and over had incomes below the poverty level in 1979. Among those who live alone in the city, 34 percent were the elderly who are 65 years and over. Nearly 77 percent of the elderly living alone are female (U. S. Census, 1990).

New York is a multi-lingual and multi-cultural city. As of 1980, almost eighty percent of the state's non-white population live in the New York city. Asian and Pacific Island Americans were seven percent of the population of New York City in 1990. The diversity in the general population exists among the elderly population. Nearly 20 percent of the older population who are 60 and older were members of minority groups in 1980.

Black, Asian, Hispanic elderly were indicated as groups experiencing problems with chronic illness and associated functional impairments (Sainer, 1986). Because of the diversity of the elderly population, New York City provides various community programs and services through ethnic groups such as the Korean American Senior Program, the Chinatown Planning Council, the Polish Slavic Center, Black churches, the Jewish Association of Services, etc.

New York City has a large Asian population. As of 1976, eighty-five percent of the New York state's elderly Asian and Pacific Island Americans resided in New York City. Almost eight out of ten of them were foreign born. Korean Americans are the third largest minority in New York City with about 70,000 Koreans living in the five boroughs. About 50,000 Koreans were living in Queens (U. S. Census, 1990).

New York City has the second largest Korean immigrant population in the U. S. About 11 percent of Korean immigrants settled there in 1986 (World Daily News, 1991b).

Among the five counties in the city, Queens is the residence of the majority of Asian residents. As of 1989, there were 600,000 Asians in New York City, and half of them lived in Queens. More than 70 percent of Korean immigrants reside in Queens whereas 47 percent of Asians live in the county (World Daily News, 1991b).

2. SUBJECTS

The subjects for this study were 48 elderly parents and 36 adult caregivers. The elderly parents were over 60 years of age, native Koreans, and immigrants. They each had a child in the United States who cared for them. The elderly subjects had at least one limitation in activities of daily living but were alert and reality oriented. When older couples were both frail, the spouses who were alert were included in the subjects. Almost all of the elderly were living in the New York City area.

Caregiver subjects were either the care receivers' adult children or daughters-in-law. All caregivers were born in Korea, immigrated to the U. S, and were identified by the elderly parents as their caregivers. The majority of the caregivers resided in the New York City area.

3. SAMPLING PROCEDURE

Because of the lack of information on the Korean frail elderly in the New York City area and limited time and finances, a non-random sampling method was utilized. However, an effort was made to obtain the representation of Korean elderly in the five counties of New York City. Table 1 presents the distribution of the elderly care receivers and caregivers in New York areas.

Table 1. Number of Care Receivers and Caregivers in Counties of New York and New Jersey

County	Care Receiver	Caregiver
Queens	33	24
Bronx	2	2
Brooklyn	3	3
Staten Island*	7	4
Bergen County	3	3
total	48	36

*Note: five of the elderly respondents were from a group home for Korean elderly.

The Korean community organizations were used to locate the sample, for many Korean immigrants in big cities are affiliated with ethnic groups and organizations (Hurh & Kim, 1984a). The majority of the Korean immigrants are members of ethnic churches (Hurh & Kim, 1984a). Especially for many Korean elderly, the community churches and agencies are the only places where they socialize with their peer group. In addition to socializing, the older people look to the community centers for information and help with applying for various public services and programs.

Because most Koreans in the New York City area see Korean physicians, the physicians were included as one of the sources of locating prospective subjects. Describing problematic physical symptoms in detail in English is thought to be difficult even to those who had college education in Korea. Many Korean physicians have their clinics in the Korean community and some of them see patients in the evening and on the weekend; therefore, it is convenient for Koreans to visit the ethnic physicians. Some Korean physicians were considered as resource persons who knew the bureaucratic medicare systems as well as good listeners to the Korean elderly's personal problems.

A total number of sixty-four Korean elderly were referred by the following four sources (Table 2). One of the sources was the Korean American community centers and voluntary organizations. The second source was Korean community churches, the third source Korean physicians, and the fourth source was personal contacts. Fifty-nine were from New York City and five were from Fort Lee, New Jersey. Four elderly persons were disqualified because of lack of cognitive skills, six refused to participate in the study, and six were too healthy to be subjects.

The sample gathering in New York City started in June and ended in the beginning of July of 1991. More people were obtained from Fort Lee, New Jersey during September of 1991 because with the subjects interviewed I had not reached the goal of fifty dyads. Fort Lee is often considered as one of the metropolitan areas of the New York City in

terms of the distance to and the residents' interactions with the city. There is a large Korean population in Fort Lee, many of whom have businesses or jobs in New York City.

Seventeen names and phone numbers were obtained from 5 Korean community organizations. Eleven were from the Korean American Senior Citizen Center in Queens and 6 from the other three organizations for Korean elderly and an association for Korean women. The four organizations which serve the Korean elderly were contacted in person and the association for Korean women on the phone.

Table 2. Distribution of Care Receiver Samples by the Sample Sources

	Agencies	Churches	Physician	Personal*	Total
Referred	17	17	14	16	64
Subjects	11	12	12	13	48

*Note: Personal contacts

The total number of 17 names was provided by the Korean community churches in New York City and Bergen county in New Jersey. The investigator contacted 25 churches randomly and 3 temples in New York City either on the phone or in person. The churches which were located in Brooklyn, the Bronx, Manhattan, and Staten Island counties were contacted more than the churches in Queens, for it had been expected that most samples would be from Queens county. Seven names were provided by the churches in Queens, 2 from Staten Island and 2 from Brooklyn, 1 from Bronx, 5 from New Jersey.

Six Korean physicians who were referred by a Korean social worker and the community centers in Queens were contacted on the phone. The name of 14 prospective subjects were obtained from the three physicians.

Sixteen names were provided by personal contacts. The personal contacts were made through the prospective elderly subjects, a beautician, a Korean social worker, home attendants who worked for the Korean elderly, and visitation to an adult home. The adult home serving the Asian elderly had the largest number of Korean elderly in New York.

Problems with Obtaining Samples

Locating frail Korean elderly immigrants was difficult for several reasons. One was that few Korean community agencies served them. When an active member of the Korean community senior center became ill or disabled, he/she tended to withdraw from community activities and socializing with their peer group.

The investigator visited the Korean American Senior Citizen Center in Queens first because the Korean elderly in New York City utilize the center most on a daily basis. The senior citizen center provides Korean lunch programs, information and referral services, assistance with mediating public services or programs, English classes, and recreational activities. This center is the only place in the city where more than one hundred Korean elderly persons gather at one time every day for lunch and socialization. Many Korean elderly who live in the city and are mobile participate in the program.

The director of the Senior Citizen Center introduced me and asked the elderly members to cooperate with my study during the lunch program. Because it was a special lunch for those who had birthdays that month, about one hundred fifty members participated in it. However only one prospective subject's name was provided at the lunch.

The difficulty of locating the subjects also was represented by the small number of Korean ill elderly for whom the Korean Community Senior Citizen Center obtained to provide home care related services. Recognizing the importance of the home care services

among the Korean elderly, the Senior Citizen Center had just finished looking for the names of the elderly who might be in need of the home care services throughout the city. The agency contacted most Korean community churches in New York City to locate the prospective clients and obtained only seven names. The center was well established and publicized among Koreans and had the largest Korean elderly members who utilized the programs on a daily basis. However they could provide only 11 prospective elderly subjects.

Although the size of the Korean community organizations for the elderly differed from one to another, they provided similar services for the elderly such as information and referral, English classes, and assistance in mediation with public services. The Association of Korean American Senior Citizens had the largest number of Korean elderly members (about 400) in New York and was located in Flushing where there is the largest Korean American population in the state. It provided one prospective subject's name. Bethel Social Service Center in the Bronx which is run by a Korean Church and serves Korean elderly in Bronx provided four names of the prospective subjects. The Social Service Center for Korean Elderly in Flushing and the Association of the Korean Women referred one each.

Despite the large size of the memberships of the Korean community organizations for the elderly, locating frail older people was difficult because the organizations were not engaged with either home care or friendly visiting services. Most of the services were provided to those who walked in to their office; therefore, the elderly who are immobile could not be reached.

Another reason for experiencing difficulty in locating frail elderly people can be interpreted by the scarcity of frail Korean elderly. Most older parents come to the United States to help their adult children not to be a burden or to be cared for. Many Korean elderly, therefore, are healthy when they arrive in the U. S. Furthermore, in order to be

eligible for public medical and social service benefits, the Korean elderly have to wait for three years after entering into the U.S. As a matter of fact, only two care receiver subjects immigrated to the U.S. during the last three years. The majority had been living in this country more than ten years at the time of the interview, and every one of them had provided help to his/her adult child with babysitting and housekeeping until they became frail.

The topic of the study, family caring for frail old parents, might be the third reason for the investigator experienced difficulty in locating the population. Several leaders of the community churches and temples expressed reluctance to identify a family with a frail older member. Some elderly persons even asked the investigator not to reveal their names as the providers of the sample names. 'How adult children take care of their disabled parents' was very sensitive topic to most Koreans I met during the research because the topic was related to the traditional family value of filial piety, and the image of the disabled elderly was unbeautiful and incompetent. Many adult children or children-in-law subjects had an apologetic attitude toward their parents because they felt they did not provide them with enough support. Some elderly subjects did not want their friends to visit them because they did not want the friends to see their disability. They could not go to the churches or community centers because they did not want to be observed as disabled persons in public who use a cane or a wheelchair.

Overall, the Korean community centers, churches, physicians, and elderly persons who were contacted wanted to help with providing prospective subjects. However, many of them could not provide any because they knew few frail elderly persons.

A total number of 64 elderly persons were contacted on the phone. Seven refused to take part in the study. Six were too healthy for the study. Three were not able to have an interview because of the lack of cognitive skills.

Caregiver Subjects

A total number of 36 caregiver subjects participated in the study. They were referred by the older parents as their caregivers. Out of the 48 elderly subjects, 44 provided names and phone numbers of their adult children or daughters-in-law who cared for them. Three older parents refused to provide the names saying that the children were too busy to take part in the study. One older person could not provide her daughter's phone number because the daughter's family had just moved to another state. From the 44 caregivers referred by their parents(or parents-in-law), eight caregivers either refused or could not make the interview. Six of them were daughters, one son, and one daughter-in-law. All of them except the daughter-in-law were not living with their parents. The daughter-in-law refused to participate in the study because she thought she was receiving support from her parents-in-law more than she provided help with them. Her family had been in the United States for several months and were living in the parents' apartment. Two of the daughters requested the questionnaires by mail but they have not been returned.

4. DATA COLLECTION

The interview schedules were translated to Korean by two bilingual (Korean English)social workers who had master's degree in social work in the United States. Items which they translated differently were brought to a bilingual English teacher who had master's degree in English Literature in the U. S. and had been teaching English for twenty years. After the translation, the questionnaires were tested by a few middle-aged adult children and healthy elderly persons. A few suggestions on wording were reflected in the final versions of the interview schedules. Concerns about the length of time required to

respond to the caregiver interview schedule were expressed and suggestions to cut down the time were implemented.

Interviews started at the beginning of July of 1990 and ended in September of 1990. The investigator called the prospective elderly interviewees to make the initial contact and to describe the study. To promote the respondents' participation in the study, the investigator stressed two points. One of the appeals was that cooperating with the study would, in the end, help the Korean elderly population and their families who care for them in the future; the findings of the study might be used as data for planning necessary services. Another appeal was that the anonymity of the respondents would be guaranteed. It was very important to emphasize that their privacy would be protected. Without exception, every caregiver and care receiver respondents wanted to know how the investigator obtained his/her name. A few even made contacts with the informants to make sure they really provided the investigator their names and phone numbers.

If the person agreed to be interviewed, the investigator made an appointment for a convenient time and place to conduct the interview. Every elderly person wanted to be interviewed in his/her residence. Interviews with care receivers were made at their residences. One of the interviews was conducted in a hospital from which the older person was expected to be discharged to a nursing home. After the interview, phone numbers of the interviewee's adult children were provided. If the caregivers were present at the time of the interviews with their parents (or parents-in-law), the interviews of the caregivers were conducted after the interviews with the parents.

A few care receivers' interviews were conducted in the presence of their Korean home attendants. The home attendants were so protective of the care receivers that they would not leave the care receivers. The care receivers stated that their home attendants knew about their family so that it was all right for them to be in the same room. Most Korean home attendants were either church members or neighbors of the care receivers and

spent more than eight hours a day with the respondents; therefore, a strong relationship had been built between them.

The adult children or daughters-in-law were contacted on the phone to describe the study and make an appointment for the interview. Unlike the elderly persons, catching the caregivers on the phone and making appointments was very difficult for they work long hours and even on weekends. There were even situations in which the investigator thought it too much to ask the caregivers to find a time for the interviews.

Many adult children or daughters-in-law wanted to be interviewed at their business or any other convenient place. This was because some caregivers worked long hours so that finding a time for the interview after work was difficult for them. Business stores, coffee shops, railroad stations, trains, and sibling's houses were picked as places for interviews and slow business hours were chosen for the time. Six unemployed caregivers and one who had business at her house were interviewed at their residences. Some caregivers were interviewed in the evening at their residences, others on Saturday morning at their residences. Two caregivers who did not have their own business and worked late could not find the places and time for the interviews so that the interview schedules were left at their parents' apartments (both were living with their parents) to be picked up. Five questionnaires were sent to those who could not have the interview in person because of their busy schedule or the distance. After sending the questionnaires, the investigator called each of them to ask whether they have any questions about it and to get information about their older parents and care behavior.

Each prospective interviewee was given a consent form which described the study and asked to sign his/her name in the document if they would agree to take part in the study. The names of three elderly subjects who could not sign because of disability were signed by their adult children.

Although the respondents agreed to cooperate with the study, many respondents were uncomfortable with writing their signatures. In some cases, the investigator had to spend some time to persuade them to sign their names. Some respondents asked how their signatures would be used. Others wrote their names in such a wild way that the names hardly were readable. It was evident that many were not comfortable with exposing their identities. As studies on Koreans(Hurh & Kim, 1984a) indicated, suspicion of unknown Koreans and 'signature phobia' were persistent among the respondents of the study.

Although the interview schedule for older subjects was designed to be taken in 30 minutes, the interview with them took from one to three hours. On the other hand, the interview with caregivers took less than one hour although it was expected to take one and a half hours. Many care receiver subjects voluntarily described how they had helped their adult children in the U. S. and the adult children were providing help with them. Some asked the interviewer about certain public services or brought letters or bills sent by hospitals or social service agencies to make sure they understood them correct. The majority of the caregiver subjects were busy with their businesses so they wanted to have the interview as short as possible. Interview schedule items about the respondents' knowledge and their utilization of the services were excluded because of the time pressure as well as the it was found that almost every elderly respondent knew and utilized certain services.

During the interview, the interviewer read the items of the questionnaire in a conversational manner. The care receivers' responses were recorded by the interviewer right after they had responded. However, in some cases, caregivers recorded their responses for certain groups of items such as filial piety and burden scale. This maneuver was taken to save the caregivers' time as well as to reduce the discomfort they might be experiencing as much as possible.

5. MEASUREMENT

In order to understand caregivers, their care behavior, beliefs about filial piety, perceived burden of caregiving, family strain, feelings of closeness to the frail older relatives, reasons of caring for the relatives were included in the items. To understand care receivers, their beliefs about filial piety and morale were included. Some of the key variables were measured by utilizing several scales.

In addition, a series of socio-demographic questions were developed to describe the two populations (Korean frail elderly parents and their adult children/daughters -in-law caregivers) and to be used in further data analysis if necessary. Items included caregivers' length of residence in the U. S., family income and working status, sex, age, marital status, and number of children, level of education and English proficiency of both groups, caregivers' relationship to older parents, availability of other family caregivers, caregivers' health status, utilization of home attendants, whether care receivers have health insurance or not, and care receivers' dependency level.

Care Behavior

For the assessment of care behavior, care behavior items were developed by the level of personal contact and time spent. The three-division concept was appropriated from the work of Cicirelli (1983). Because of the nature of the population, health and cultural aspects of care behavior were added to the concept.

The primary group of care behaviors included personal care, instrumental care and health care. Personal care was composed of seven care tasks which involved assistance with 1) moving in and out of bed/chair, 2) eating, 3) dressing, 4) grooming, 5) bathing, 6) toileting, 7) cleaning up after toileting. Instrumental care included five tasks, assistance

with 1) house cleaning/laundry, 2) meal preparation, 3) house maintenance, 4) groceries and shopping, 5) transportation and companionship. Health care included five care tasks, which are assistance with 1) calling physicians at the elderly's request or when symptoms are shown, 2) taking medication or treatment, 3) knowledge about side effects of the medicine or treatment, 4) maintaining the safety of the residence (e.g., any obstacles that might cause falls on the stairs, floor, kitchen, or bathroom). 5) nutritional diet.

The personal, instrumental, and health care items required the respondents to indicate some level of engagement with each item. The personal and instrumental scales were scored on a six-point scale (i.e., 0= not provided, 1= less than a week, 2= once a week, 3= every 4-5 days, 4= every 2-3 days, 5= every day). The scale for health care was scored on a four-point scale (i.e., 0= not provided, 1= seldom, 2= often, 3= nearly always).

The secondary care included socio-emotional care (Cicirelli 1983), moral supports, and protection. Emotional care included 1) bringing reading or recreational materials or gifts, 2) taking the elderly person to a social gathering and church, 3) having the elderly person participate in the family gatherings or outings, 4) spending time to talk to and listen to the elderly person, 5) being with the elderly person when they do not feel well. Moral support included 1) respecting the elderly parents' life experience, 2) asking for advice regarding family and other social matters, 3) serving the elderly first at meals, 4) showing respect on other social occasions, 5) when shopping or preparing meals for the older parents, choosing the menu and items that they like. Protection care included 1) managing financial and legal matters, 2) obtaining information about benefits and programs, 3) arranging and supervising the provisions of public or private care services such as social services and hospitals.

For the measure of emotional and moral supports, the respondents were required to indicate the level of frequency on each item. The protective care measure was designed for the respondents to indicate the amount of time they spent a month for tasks on each item.

Emotional and moral support was measured on a four-point scale (0= not provided, 1= seldom, 2= often, 3= nearly always). Protection care was scored on a six-point scale (i.e., 1=0, 2=less than 20 minutes, 3= 20-39 minutes, 4= 40-59 minutes, 5= 60-89 minutes, 6= 90 minutes and more per month).

The third dimension of the care behavior was financial support. Financial support was measured by the percentage of financial contributions to the elderly's monthly living expenses.

Living Arrangements. When living arrangements were analyzed as a part of care behavior, it was dummy coded (i.e., 0= not living with caregiver, 1= living with caregiver). Otherwise, it was divided into three groups; living with caregivers, living separately, and living in institutions.

Filial Piety. The Filial Piety scale (Ho & Lee, 1974) was utilized to measure the caregivers' and care receivers' beliefs on filial piety. The respondents were required to indicate some form of agreement or disagreement with each of 22-item. The score of each respondent was made based on a seven-point scale (i.e., 1= strongly disagree, 2= disagree, 3= mildly disagree, 5= mildly agree, 6= agree, 7= strongly agree, 4 was omitted). Negative items were scored in reverse. A higher score means a stronger belief in the concept of filial piety.

Caregiver Burden. Caregiver burden was measured by the Burden Interview (Zarit et al., 1980). The 22-item scale was designed for caregivers of demented, aged patients. However, it has been useful to measure the adverse effect of caregiving on non-demented patients (see Stone, 1987). The respondent was required to indicate some level of their

perceptions on each item. Caregiver burden was measured on a six-point scale (i.e., 0= never, 1= rarely, 2= sometimes, 3= quite frequently, 4= nearly always).

Family Strain. Family caregiving strains were measured by the caregivers' perceived level of stress in the five areas: 1) management of housekeeping, 2) relationship among family members, 3) family social life, 4) personal life of the family members, 5) job performance.

The family strain scale was a Likert-type scale which required the respondents to indicate some form of agreement or disagreement with each item. Family strain was measured on a four-point scale (i.e., 1= not agree 2= agree a little, 3= agree 4= strongly agree).

Morale. The care recipients morale was measured by the Philadelphia Geriatric Center (PGC) Morale Scale (Lawton, 1972), since this measure was designed to assess multidimensional aspects of aging including social relationship. The Morale Scale is composed of seventeen items which measure a global psychological state of elderly people. The scale is a Likert type : a respondent is asked to respond whether he/she agrees with each of the items. If she/he agrees with an item, a score of 1 is given. The items which are not answered receive no numerical score. The higher the individual's score is, the higher her/his morale is.

Availability of Other Family Caregivers. Other family caregivers included caregivers' spouses, caregivers' siblings (or siblings-in-law), and care receivers' spouses. If the other caregiver is available 1 score was given: each of the family caregivers was a dichotomous variable (i.e., 1= if the caregiver was available , 0= if the caregiver was not available).

Elderly Disability. Elderly disability was measured by three previously developed scales: for activities of daily living and the instrumental activities of daily living (Lawton & Brody, 1969) and for cognition (Poulshock & Deimling, 1984). The caregivers were

asked to rate each item on the three scales. The measures of activities of daily living (ADL) and instrumental activities of daily living (IADL) were obtained by asking each caregiver to rate the elderly's level of each activity on a 5-point scale (1= the elderly need no help, 2= need some help, 5= need full assistance). The ADL measure had 6 items which included toileting, eating, moving in and out of the bed or chair, dressing, grooming, and bathing. The IADL measure had seven-items which included telephoning, shopping for groceries and personal items, laundry/cleaning house, preparing meals, being mobile, managing medicine, billing and banking. The measure of cognition was obtained by asking the caregiver to rate on a 3-point scale how often the elderly show the specific symptom on each of the five items. The items include forgetfulness, confusion, hearing or seeing something that is not there, talking to oneself, repetition of a statement.

6. DATA ANALYSIS

The data analysis had three stages. The first was coding the interview responses. The response of each item was placed in the appropriate category. The second stage was tabulating the data. The third stage was performing statistical computations. The data were analyzed using the Statistical Analysis System (SAS, 1990) and Statistical Package for the Social Sciences (SPSS, 1990).

The following statistical procedures were used to analyze the data in the study: descriptive statistics, multiple regression, logistic regression, Pearson's product moment correlation, and canonical correlation analysis.

1. Descriptive statistics such as frequency distributions, measures of central tendency and dispersions were utilized to describe the two groups of samples, the caregivers and care receivers. The primary focus was on the caregivers for the socio-demographic description

of the caregiver sample (e.g., sex, age, relation to care receivers, length of residence, family income, working hours, education of the head of the family, etc.).

Frequency distributions were used to describe the involvement in care behavior.

2. Internal consistency coefficients of the scales used in the study were computed using Cronbach's alpha.

3. Multiple regression and logistic regression were employed to answer the first research question. The first research question was composed of two sub-questions as follows.

a. Will caregivers' socio-demographic variables (family income, length of residence in the U. S., employment status, availability of other family caregivers) be related more than filial piety to their care behavior?

b. Will the caregivers' filial piety be related to the emotional and moral support?

Logistic regression was an appropriate technique to analyze the relationships with living arrangements, one of the care behaviors, since this variable was a binary variable (living with ill parent=1, not living with ill parent=0).

4. Pearson's product moment correlation (one-tailed) was used to answer the second research question whether caregivers' length of residence in the U. S. is related to the utilization of outside help in caring for their frail parents.

5. Multiple regression analyses were utilized to answer research questions 3 and 4. The followings are the research questions.

a. Will the characteristics of care receivers be related to the caregivers' perceived burden?

b. Will the characteristics of caregivers be related to their perceived burden?

Variables entered in the first model include dependency of care receivers, living arrangements (live with caregiver=1, not live with=0), gender of the care receivers (0=F, 1=M), whether care receivers have another child as their caregiver, whether care receivers' spouses are caregivers, relation to caregivers (parent=1, parent-in-law=0). The variable,

whether care receivers have health insurance or not, was excluded, for almost every care receiver respondent had medicaid insurance.

Independent variables entered in the second burden model are caregivers' working hours, health, whether caregivers have children who are twelve years old and under (If have=1, If not=0), availability of other family caregivers (their spouses, care receivers' other children, or spouses), caregivers' feelings of closeness to the care receivers (0=no feeling, 3=very close). In order to find predictors of burden, coefficients of predictors were computed. The significances for the coefficients were tested by their *t* values.

6. Multiple regression was used to answer the fifth research questions: whether the caregivers' family income and length of residence are related to their family strain. R square and coefficients of the two predicted variables were calculated. To test the significance of the coefficients, *t* values were calculated.

7. Multiple regression analysis was used to answer the sixth research question, whether there are relationships between the type of care behavior, the level of care receivers' disability and their morale.

8. Canonical correlation analysis was employed to describe the overall relationships between the characteristics of caregiver and care receivers and care behavior. The purpose of using canonical correlation analysis was to find out the interrelationships among the sets of dependent and independent variables.

CHAPTER III

RESULTS

To help the reader to understand Korean American family caregiving, it is necessary to describe the living conditions of the elderly and how caregiving is arranged in the family. The first section describes the residences of the elderly. The second section discusses the relation between caregivers and their older relatives. The third section will describe the caregiver siblings' care behavior.

1. RESIDENTIAL AREA OF THE ELDERLY

Almost all elderly in this study lived in an urban area. The majority of the elderly respondents lived in Elmhurst and Flushing, Queens county in which the largest Korean population is concentrated in New York. The areas are known to be the fringes of the ghetto; the majority of residents in these areas are Asians and other ethnic minorities. There are commercial as well as dwelling zones. Old apartment buildings, small stores, offices of ethnic minority physicians, and small parks line the streets. Many store signs are written in Korean or Chinese. Subway and bus stations are near. Some of the pedestrian sidewalks are too rough for an individual who uses a cane or wheelchair. Crime rates are high. Residents in the areas often hear their neighbors have been robbed on the street, at the subway station, in the apartment or at the stores. During the interview period, two of the elderly respondents' adult children were robbed.

Elderly care recipients who had separate housing were living in one-bedroom or one room apartments. Some were living in public housing or housing subsidized by the

public. Others who could not have public housing were living in unsubsidized apartments. In this case, the elderly either had a roommate or did babysitting or both in order to pay the high rent. Some apartments did not have elevators, the elevators of other apartments were often broken. A male subject living on the third floor and in the recuperating period after a broken hip could not go out because of the stairs. A female subject was not able to go to church on Sunday because the elevator was broken. Despite the impoverished nature of the environments, there are advantages for the Korean elderly. They can walk to the Korean grocery stores, pharmacies, and the clinics of native physicians. There are Korean community centers in the neighborhood. Those who are unable to use public transportation can utilize Korean taxis 24 hours a day. Most importantly, the cultural contexts are not as threatening as the suburbs. Without a car and English skills, the older people can manage a certain level of daily living and social interactions with other Koreans.

The Korean elderly who live in other parts of the New York metropolitan area do not have as many advantages as do the elderly in Queens. Whereas most elderly in New York City lived in old apartment buildings, all the elderly in New Jersey lived with their children. Although there are Korean neighbors, stores, and churches in their residential areas, there are only few places they could walk to. No Korean community center for the elderly was available. Some elderly had a Korean store deliver their groceries. Transportation was a serious problem, for most were unable to use public transportation because of their physical condition. Many could not afford a taxi. An old lady wanted to see a Korean native physician in Queens, but she did not know when she could have the transportation. A male subject in the Bronx had made the long trip to Queens by public transportation to go to the Korean American Senior Citizen Center for lunch and socialization. Now he could not make the trip anymore because of his poor health. As a result, the elderly in New Jersey had the most limited social activity.

Despite the frequent social interaction with their ethnic group in New York City, many Korean elderly experience difficulty finding someone to assist them when needed. When they needed help with reading mail from hospitals or bureaucratic offices or going to the places which involve speaking English, they have a hard time finding a helper. In many cases, understanding the letters and accompanying the elderly to the offices require knowledge of English as well as of the American medical and social system. Some adult children either could not help their parents because of the lack of English proficiency or did not have the time to help them. Many elderly utilize Korean voluntary offices and workers charging minimum pay despite their limited budget. There are Korean community centers which provide the elderly services free of charge. However, they are not in walking distance, and the services are not as effective as are the voluntary workers'.

Many elderly find it hard to find someone to whom they can confide their problems. The interaction with their neighbors or peers in the residential area is often superficial. Some elderly discuss their personal or family problems with their physicians during the check-up. Korean physicians sometimes spend more time in listening to the elderly than providing medical care. According to a physician, some elderly's problems are serious enough to get professional attention.

A few leisure activities are available to the Korean elderly of the study. The most popular one is watching the Korean television program which is on daily by satellite from Korea. Those who live in public housing socialize with Korean peers in the same apartment. Many had participated in lunch or other services in the Korean community centers; however, they no longer could go there because of physical limitations. Those who are severely disabled depend on their Korean home attendants for companionship. Some who have a spouse sometimes go with their assistance to the neighborhood park to watch people or chat with other Korean elderly. It is evident their leisure activities are reduced by their physical limitations.

For the Korean elderly, church adds a lot to their life. It is a place for socialization. Almost every subject in the study was a church goer. Most elderly who do not live with their children go to a different church from the children's and the transportation is provided by the church or people other than their children. Some elderly saw their children at the church. Some elderly spend time reading the Bible and going to the church nearby daily. Church appears to be much more than a simple place to socialize to these elderly.

The nursing homes the investigator visited were in Queens and Fort Lee, New Jersey. One was located on a busy street, the other in a suburban area. The Korean residents' children lived within 30 minutes from the facilities and made frequent visits. Some elderly listen to the Korean Christian radio broadcasting or gospel tapes. Some shared a room with a Korean. There are few Asian residents, and few employees speak Korean. No Korean ethnic food is available. A Korean resident told the investigator that the place and employees just scared her. In a dining room, an American resident yelled at her, and an employee nearby raised her voice to protect the Korean woman. However to the Korean resident, the facial expression and voices of the two people looked like they both were angry at her. Sometimes their basic needs were not met because of communication problems with the employees.

The environment of the adult home had some cultural familiarity to Korean elderly residents. Almost all the residents were Asians. The great majority were Chinese and rice was served frequently at meals. The adult home is located in a low class residential area in Staten Island where Korean immigrants are dispersed throughout the city. Most Korean residences are from Queens county. A strength of the facility is the availability of socialization among the Korean elderly. Eleven Korean residents lived on the same floor when the investigator visited and most were mobile. Some had their own rooms with small refrigerators in them; others had Korean roommates. Some chose the adult home by

themselves because of their physical limitations. Others agreed with their children's suggestion to move in. Most were satisfied with living there.

Although some Korean residents had few physical limitations, their social activities were limited. They rarely went out because of transportation. On Sunday, the Korean church provided transportation to church. A resident recently arrived from another state found the place was different from what she had expected. She wanted to go to Queens to find an apartment but she did not have anyone around to assist her. Her adult children decided not to be involved with her for some time to give their mother a lesson; let her miss and appreciate her family so that she would never say that she would move away from her family. Another Korean resident was preparing to move out to the community because she could not tolerate the food in the Home. Some elderly experienced difficulty relating closely to the other Korean residents because their educational and social backgrounds were different. When English was involved, one of the residents who could speak English was contacted. Only several of them had telephones. Those who did not have a phone had very limited contacts via through the Korean residents' phone.

2. DESCRIPTION OF SAMPLE GROUPS

A. Caregivers

Of the 36 caregivers who participated in the study, 16 (44%) were daughters, 10 (28%) were daughters-in-law, and 10 (28%) were sons of the care receivers. In terms of relationship with care receivers, 21 (58%) were mothers of the caregivers, 5 (14%) fathers, 5 (14%) mothers-in-law, and 5 (14%) fathers-in-law (Table 3).

As table 4 presents, 12 (34%) of the 36 caregivers lived with their parents or parents-in-law, 18 (50%) had their care receivers in separate households, 4 (11%) in an adult home and 2 (5%) in nursing homes. Out of the 12 caregivers who live with their parents, 7 were the care receivers' sons or daughters-in-law, 5 daughters. Four care receivers lived in an adult home which is known to be the adult home for Korean elderly because the number of Korean elderly is the largest among the adult homes in New York City and the facility provides Oriental food. The nursing homes were located in Queens county where there was the largest Korean population in New York.

Table 3. Living Arrangements of Care Receivers by Caregivers

Living Arrangements	Daughter	Son	Daughter-in-law	Total
Live with ¹	5	4	3	12
Live separately	8	5	5	18
Institutions ²	3	1	2	6
Total	16 (44%)	10 (28%)	10 (28%)	36

Note: 1=The elderly are living with caregivers. 2= nursing homes or adult homes.

Table 4. Distribution of Caregivers by Their Relationship to Care Receivers

Mother	Father	Mother-In-Law	Father-In-Law
21(58%)	5 (14%)	5 (14%)	5 (14%)

The mean age of the caregiver group was 43.55 years (SD=7.99), while the mean age for women was 40 and for men 45 years. The ages of caregivers ranged from 25 to

61. One caregiver was less than 29 years, 10 were between 30-39 years, 19 between 40-49, four between 50-59, 2 were over 60 years of age (Table 5).

Table 5. Distribution of Male and Female Caregiver by Age

Age Group	Male	Female	Total
20-29		1	1(3%)
30-39	4	6	10(28%)
40-49	3	16	19(53%)
50-59	2	2	4(11%)
60-69	1	1	2(5%)
Total	10 (28%)	26 (72%)	36(100%)

Note: Mean : 43.55

Std. Dev.: 7.99

In regard to marital status, 32 (89%) caregivers of the study were married, 1 was separated, 1 divorced, 1 widowed, and 1 single (Table 6). All caregivers who were living with their older parents were married.

Table 6. Distribution of Caregivers by Their Marital Status and Sex

Marital status	Male	Female	Total
Married	10	22	32 (89%)
Separated/divorced		2	2 (5%)
Widowed		1	1 (3%)
Single		1	1 (3%)
Total	10	26	36 (100%)

Of the caregiver group, 23 had two children or less and 6 had three or more children. Seven did not have a child. The mean number of children was 1.7 (SD=1.3). All 36 care receivers had one or more children. The mean number of children was 5.2(SD=1.58).

The mean years of residence in the U. S. for the caregivers was 13 years (SD=5.05). Three (8%) had lived here less than 5 years, 9 (25%) between 6-10 years, and 24 (67%) had lived here more than 11 years (Table 7).

Table 7. Length of Residence in the United States by Caregivers and Care Receivers

Yrs in Residence	Caregiver	Care Receiver	Total
0 - 5	3 (8%)	4 (11%)	7 (10%)
6 - 10	9 (25%)	10 (28%)	19 (26%)
11 - 15	9 (25%)	16 (44%)	25 (35%)
16 and over	15 (42%)	6 (17%)	24 (33%)
Total	36(100%)	36 (100%)	72 (100%)

Note: Mean: 13 years, Std. Dev.: 5.05 for caregivers.

Mean: 12 years, Std. Dev.: 4.66 for care receivers.

In regard to monthly family income of the caregivers, 9 (25%) had less than \$2,000, 15 (42%) between \$2,000-4,000, and 12 (33%) more than \$4,000 (Table 8).

In terms of the educations of the head of the caregivers' family, a vast majority had college educations. Only 4 (11%) reported the final education was high school (Table 9).

Table 8. Distribution of Caregivers and Care Receivers by Their Monthly Income

Income Range	Caregiver N & %	Care Receiver
\$500 and less		36(100)
\$1,000-1,499	3 (8)	
\$1,500-1,999	6 (17)	
\$2,000-2,499	6 (17)	
\$2,500-2,999	3 (8)	
\$3,000-3,999	6 (17)	
\$4,000-4,999	5 (14)	
\$5,000 and over	7 (19)	
Total	36 (100)	36 (100)

Table 9. Level of Education of Caregiver' Heads of the Family and Care Receivers

Education level	Caregiver	Care receiver	Total
No schooling		6 (17%)	6
Grade school		11 (31%)	
High school	4 (11%)	11 (31%)	15
Some college	9 (25%)	7 (19%)	16
College	19 (53%)		19
Post graduate	4 (11%)	1 (3%)	5
Total	36 (100%)	36 (100%)	72

Occupational level was determined by the head of the family of caregivers. Nineteen (54%) were small business owners, 7 (19%) were sales and clerical workers, 7 (19%) were professionals, 2 (5%) had semiskilled occupations and 1 service occupation. In most cases, the husband's occupation determined the occupational level of the household (Table 10). In terms of the number of family members who worked, 23 (66%) had two and 12 (34%) had one.

In terms of working status of the caregivers, 30 (84%) were employed. Of the 30, 27 (90%) worked more than 40 hours a week: 15 (50%) worked between 40-59 hours, 12 (40%) worked more than 60 hours. Three (10%) worked less than 40 hours (Table 11).

Those who were not employed either had children under 12 years of age or they had problems with their health.

Table 10. Distribution of Caregivers by Occupational Status of the Head of Their Family

Occupational status	N	%
Professional	7	20
Manager, Proprietor	19	53
Clerical, Sales,	7	19
Semiskilled, Operative	2	5
Service Worker	1	3
Total	36	100

Table 11. Weekly Working Hours of Caregivers by Sex

Working Hours	Male	Female	Total
0		6 (23%)	6 (16%)
21-39		3 (12%)	3 (8%)
40-59	5 (50%)	10 (38%)	15 (42%)
60 and over	5 (50%)	7 (27%)	12 (33%)
Total	10 (100%)	26 (100%)	36(100%)

Regarding the ethnicity of the employers of the caregivers, most employers were Koreans. 86% (31), including self-employed, worked for Koreans and only 14% (5) worked for non-Koreans.

In regard to the level of caregivers' English proficiency, the majority (50%) reported that they could speak English without assistance, 12 (33 %), needed other's assistance now and then, 6 (17%), often needed the assistance. In terms of the level of English writing skills, the majority (75 %) indicated that they needed help. Only 9 (25%) caregivers said they did not need help (Table 12).

Table 12. Distribution of Caregivers by the Level of English Skills

Level of English	Speech	Writing
No help needed	18 (50%)	9 (25%)
Need help sometimes	12 (33%)	14 (39%)
Need help often	6 (17%)	10 (28%)
Need help always		3 (8%)
Total	36 (100%)	36 (100%)

Fifteen of the caregivers (42%) had been caring for their parents(or parents-in-law) more than three years, 3 (8%) between 2 and 3 years, 6 (17%) between 1-2 years, and 12 (33%) less than a year.

In terms of geographical proximity, more than one half of the caregivers lived within thirty minutes driving range and 25% of them lived more than an hour away. (Table 13).

Table 13. Geographical Proximity between Caregivers' and Care Receivers' Residences by Minutes Taken by Car

Minutes	Caregiver
15 & less	8(33%)
16 - 30	6(25%)
31 -45	4(17%)
60 & more	6(25%)
Total	24(100%)

The majority of the caregivers who did not share a household with their older relative had frequent contacts with the elderly. More than 80% of them reported they called and visited their parents once a week or more. As Table 14 presents, 38% of the caregivers called the elderly daily and only 17% less than once a week. One half of the caregivers made a visit to the older relatives 2-3 times a week.

Table 14. Level of Caregivers' Contacts with Their Parents/parents-in-law by Telephoning and Visiting

Level of contacts	Telephoning	Visiting
Less than once a week	4 (16%)	3(13%)
Once a week	1 (4%)	5(21%)
Every 4-5 days	1 (4%)	4 (17%)
Every 2-3 days	9 (38%)	8 (33%)
Everyday	9 (38%)	4 (16%)
Total	24 (100%)	24 (100%)

In terms of availability of other family caregivers, 81% (29) had siblings or siblings-in-law as other caregivers. Thirty-nine percent (14) had their spouses and 28% (10) the elderly's spouses as other caregivers. Four of the caregivers had all three family caregivers and 7 did not have any of them.

In terms of religious preference of caregivers, 70% (25) were protestant, 25% (9) were catholic. Regarding the caregivers' health status, 72% (26) rated their health good, 14% (5) fair, and 14% (5) bad.

The majority of caregivers reported the reasons for caring for their older relative were because they loved them as well as it was a moral duty. Nine (25%) stated it was a moral duty. Three caregivers (8%) responded they cared for their parents because there was no other caregiver. Multiple responses were allowed (Table 15).

Table 15. Distribution of Caregivers by Reasons of Caring for Their Parents

Caring reason	Daughter	Son	D-In-Law	Total
Moral duty	8 (31%)	5 (50%)	8 (80%)	21(58%)
Love	10(38%)	7 (70%)	4 (40%)	21(58%)
No one else ¹	3(12%)	3 (30%)	3 (30%)	9 (25%)
Total	26	10	10	36

Note: 1= No other family caregiver was available.

In terms of the major problem with caregiving, 43% reported not having enough time for their parents, 23% emotional conflicts with parents/parents-in-law. They felt guilty, stressed and experienced incompatibility with the older relatives. Seventeen percent of the caregivers indicated a lack of financial resources and 3 percent poor health as the problem. One of the caregivers stated she felt anxious when she was away from home because she needed to worry about her mother; another indicated poor maintenance of housekeeping(because of his mother's illness) as problematic. Still others indicated the relationship between the older parent and their children as a problem (Table 16).

A great majority indicated caring for their parents/parents-in-law was helpful to their family. Seventeen respondents stated that they could teach their children about filial piety. Four respondents stated that caring for their older parents would be one of the ways to maintain the traditional family system.

A large proportion of the caregivers (83%) stated that they felt rewarded by providing help to their older parents/parents-in-law. Only 6 caregivers (17%) said that they did not feel rewarded.

Table 16. Distribution of Caregivers by Their Major Problem with Caregiving

Major problem	N and %
Poor health	3 (9)
Lack of financial resources	6 (17)
Do not have enough time	15 (43)
Emotional conflicts	8 (23)
Other	3 (8)
Total	35 (100)

Note: One caregiver did not respond.

Out of 36, 24 (67%) caregivers stated that their care behavior would be different if they had been in Korea. Twelve said their care behavior would be the same as what they had been doing.

In summary, most caregivers were married. The majority were female(daughters and daughters-in-law). Their age had a wide range however, the majority were middle-aged. Most of the caregivers have lived in the U. S. for 10 years or more. Most of them had children of their own.

One-third of the caregivers lived with their older relatives. Most lived within 30 minutes drive distance from the elderly. Two-thirds had contacts with the older relatives more than four times a week.

A vast majority of the caregiver couples were employed. A great proportion of the caregiver's family head received a college education. Many were the owners of small businesses and the majority had a monthly family income of \$3,500 or more.

Most caregivers had either siblings or siblings-in-law as other caregivers. More than half of the caregivers had formal helpers for their older relatives.

B. Care Receivers

Of the 36 care receivers, 10 were male and 26 female. Their ages ranged from 60 to 86 years. The mean age for this group was 75.72 years (SD=6.96). The number of care receivers for the age range 60-69 was 8, for the 70-79 age range 15, for the 80-89 age range 13 (Table 17).

The mean years of residence of care receivers in the U. S. was 12 (SD=4.66). Four care receivers (11%) had lived in the U. S. less than five years, 10 (28%) between 6-10 years, 16 (44%) between 11-15 years, and 6 (17%) more than 16 years (Table 7).

Table 17. Distribution of Care Receivers by Age and Gender

Age group	Female	Male	Total
60 - 69	5	3	8 (22%)
70 - 79	10	5	15 (42%)
80 - 89	11	2	13 (36%)
Total	26	10	36 (100%)

Note: Mean: 75.72 Std. Dev.: 6.96

Thirteen (36%) of the care receivers were married, 2 (6%) separated, and 21 (58%) widowed. Among the 12 elderly who were living with the caregiver children, 10 were widowed females and 2 were married males. The two males and their wives were living with their children's family because they did not have any income (Table 18).

Four older parents provided housing to their single adult children who could not afford housing. Despite cohabitation, the parents did not identify the children as their caregivers.

The majority of the elderly respondents(65%) were satisfied with their living arrangements. Most who were dissatisfied with their living arrangements were those who were living with their adult children.

Table 18. Living Arrangements by Care Receivers' Marital Status

Living Arrangements	Married	Separated	Widowed	Total
Live with children	6	0	10	16 (44%)
Live separately	7	1	6	14 (39%)
Institution	0	1	5	6 (17%)
Total	13(36%)	2 (5%)	21(58%)	36(100%)

Almost all of the elderly respondents had one or more health problems. The most common medical problems included effects of stroke(26%), cancer (11%), and diabetes (11%). Other health problems of the respondents included arthritis, heart trouble, tuberculosis, circulation trouble in arms or legs, liver disease, and bladder problems. Seven (19%) had problems with eye sight and six(17%), had hearing problems.

In terms of the level of the Activities of Daily Living (ADL), 11 (30%) elderly were rated in need of assistance with toileting at least once a week. About 60% of the elderly were rated they needed assistance with eating, 40%, with grooming. A great majority (78%) used prosthetic devices or personal assistance to be mobile. Only eight (22%) were rated to be able to go out into their neighborhood without the assistance. About 40 % of the elderly were rated to be in need of help with bathing.

In terms of the level of the Instrumental Activities of Daily Living (IADL), almost all care receivers were rated to be in need of help with more than one activity. Only 3 elderly were rated to be in need of assistance with making a call (Table 19).

All 36 elderly had medical insurance. A large proportion of the elderly respondents (83%) had Medicaid and Medicare B. Four respondents had Medicaid only and three had Medicaid and Medicare A.

In terms of monthly income of the care receivers, 64% had incomes between \$300 - \$500 a month. The main income source was Social Security Supplemental Income. Thirty-four of the care receivers were the recipients of the benefit (Table 20).

Out of 36, twenty elderly (56%) had formal caretakers. Fourteen had home attendants. Twelve of them had the home attendants' services more than 40 hours a week. Six elderly people were in nursing homes or an adult home.

A great majority of the widowed elderly reported they were dependent on their adult children most in receiving care. Of the 13 married elderly, 8 reported they depended on their spouse most. Only 2 reported they relied on their daughters-in-law.

In terms of the person whom the elderly contacted most, the majority of the elderly group reported their son and daughter. Only one reported their daughter-in-law as the person (Table 21).

In summary, the majority of care receivers were female and parents of the adult children caregivers. The elderly group was quite old. Most were over 70 years of age and one third were over 80. Most have lived in the U. S. for more than 11 years and the majority live alone.

Most of the elderly were moderately disabled. Widowed elderly depended on their children whereas married aged relied on their spouses for the management of daily living. They had Medicaid insurance and minimum income of SSI. About 40 percent of them were receiving home attendants services.

Table 19. Distribution of Caregivers' Rating the Elderly by the Level of Their Disability

Activities of Daily Living	Help Needed
Mobility	28 (78 %)
Eating	28 (78 %)
Grooming	23 (64 %)
Dressing	16 (44 %)
Bathing	15 (42 %)
Toileting	11 (31 %)
Instrumental Activities of Daily Living	
Housekeeping	35 (97 %)
Meal preparation	34 (94 %)
Shopping for groceries	33 (92 %)
Management of money	32 (89 %)
Public Transportation	30 (83 %)
Management of medicine	11 (31 %)
Telephoning	3 (8 %)

Table 20. Distribution of Care Receivers by Monthly Income

Monthly income	N and %
\$300 and less	3 (9)
\$300-499	21 (64)
\$500-699	3 (9)
\$700-899	2 (6)
\$900-1,199	1 (3)
\$1,200 and over	2 (6)
No answer	4 (12)
Total	36 (100)

Table 21. Distribution of the Persons Care Receivers Depend on and Contact Most

Person Depended On	N & %	Person Contacts With	N & %
Daughter	12 (33)	Daughter	15 (42)
Son	11 (31)	Son	17 (47)
Daughter-In-Law	2 (6)	Daughter-In-Law	1 (3)
Elderly's Spouse	8 (22)	Elderly's Spouse	1 (3)
Others	3 (8)	Others	2 (5)
Total	36 (100)	Total	36(100)

C. Description of Care Behavior

Twenty-five percent of the caregivers reported they provided personal care. Helping with eating was performed most and moving in and out of the bed, least among the care activities (Table 22). All care providers except one were female. Six of them lived with the elderly and those having separate housing lived within 20 minutes drive distance.

Caregivers received help from siblings/siblings-in-law and/or home attendants. A daughter-in-law cared for her disabled mother-in-law with the assistance of her husband. Her sister-in-law visited the mother once a week after work to give her a bath. In another case, a daughter brought her mother to her house for weeks several times a year to give her sister-in-law a break. A daughter who lived in another state had her vacations at her mother's residence to take care of her.

Those who were severely disabled were receiving long hours of home care services.

About 50% of the caregivers reported they were engaged in at least one of the instrumental care tasks. Assistance with grocery shopping was performed most and house maintenance least. Female caregivers were likely to provide a greater level of help with cleaning and house maintenance. Male caregivers provided transportation services more than did their female counterparts.

A great majority of the caregivers provided help with making an appointment with a physician for the older relatives. However the level of assistance with medication or treatment was very low. This may be because only half of the parents were rated to be in such need. Again some care tasks were gender oriented: female caregivers were likely to provide nutritional food more than were male caregivers (Table 22).

Table 22. Distribution of Primary Care Behavior by Caregiver Gender

Primary Care	F (N & %)	M (N & %)	Total
Personal Care			
Eating	7 (19)	1 (3)	8 (22)
Grooming	7 (19)		7 (19)
Bathing	7 (19)		7 (19)
Dressing	6 (17)		6 (17)
Toileting	4 (11)		4 (11)
Cleaning after toileting	4 (11)		4 (11)
Moving in and out of bed or chair	2 (6)		2 (6)
Instrumental Care			
Grocery shopping	14 (54)	5 (50)	19 (53)
Providing transportation	9 (35)	7 (70)	16 (44)
Preparation meals	11 (42)	1 (10)	12 (33)
Laundry/cleaning house	9 (35)	1 (10)	10 (28)
House maintenance	6 (23)	0	6 (17)
Health Care			
Arranging medical appointment	21 (85)	9 (90)	30 (83)
Provide nutritional food	20 (77)	4 (40)	24 (67)
Check the safety of the residences	15 (58)	7 (70)	22 (61)
Obtain information of medicine	16 (62)	4 (40)	20 (56)
Help with medication	10 (38)	2 (20)	12 (33)

In terms of emotional support, a great majority reported they listened to and were with their parents when parents did not feel good (see Table 23). "Bringing recreational material" and "taking to churches" were the least practiced emotional care tasks. This may be because the elderly enjoyed a Korean T.V. program which was on daily so that many caregivers did not feel the need to bring additional recreational materials. Most elderly who did not live with the caregivers were taken to churches by others.

The level of involvement with moral support was greater than any other secondary care behavior. More than 50% of the caregivers participated in all five activities of moral support. Almost all reported they respected their parents. However they did not ask for parents' advice for the family matters as much as they respected them.

Fewer caregivers reported they were involved with protective care. Forty-four percent of the caregivers spent more than 2 hours a month to arrange and supervise the provision of formal services for parents/parents-in-law. Only 22% provided assistance with paying the bills and banking. Most elderly with separate housing used money orders to pay their bills and those who lived with the caregivers did not need to pay any regular bills (Table 23).

A great majority (83%) of the caregivers responded that they provided financial support to their parents: 17 (47 %) contributed 25 percent of their parents' monthly living expenses, 13 (36%) more than 50 percent. Except one, every caregiver who contributed more than 50 percent was living with their parents/parents-in-law.

Table 23. Distribution of Secondary Care Behavior by Caregiver Gender

Secondary Care	F (N & %)	M(N & %)	Total
Emotional Support			
Spend time to listen to parents	21 (81)	6 (60)	27 (75)
Be with them when they do not feel good	20 (77)	5 (50)	25 (69)
Taking to the family outings	14 (54)	6 (60)	20 (56)
Taking parents to social gatherings	11 (42)	5 (50)	16 (44)
Bringing recreational material	10 (39)	4 (40)	14 (39)
Moral Support			
Respect parents in social activities	21 (84)	10 (100)	31 (86)
Choose the items parents like	22 (85)	7 (70)	29 (81)
Serve parents first at meals	21 (84)	6 (60)	27 (75)
Respect parents' life experience	17 (65)	8 (80)	25 (69)
Ask for advice	16 (62)	4 (40)	20 (56)
Protection Care			
Obtain information about services	12 (46)	3 (30)	15 (42)
Arrange provision of services	11 (42)	4 (40)	15 (42)
Pay bills and banking	5 (15)	5 (50)	10 (28)

In summary, the Korean American adult children/daughter-in-law caregivers studied supported their older relatives by sharing a household or having frequent contacts with them living close to them. Most caregivers supported their older parents emotionally, morally, and financially. However the level of their engagement in the instrumental care and mediation of bureaucratic services was very low. This may be because more than half of the elderly received help from the formal helpers for hands-on services. Many provided financial support in the form of pocket or grocery money.

Some care activities were gender specific. Female caregivers were likely to provide help with personal aid, housekeeping and cooking more than the male caregivers. Sons were likely to provide more help with transportation.

3. INTERNAL CONSISTENCY OF THE SCALES

Internal consistency coefficients of the scales used in the study were computed using Cronbach's alpha. Table 24 presents the scales with the minimum and maximum score, mean, standard deviation, number of items, and alpha.

Table 24. Internal Consistency Coefficients of the Scales

Scale	Mininum	Maximum	Mean	SD	N of item	Alpha
ADL	7	23	12.39	4.34	6	.87
IADL	12	28	20.61	4.61	8	.86
Cognition	6	15	13.78	2.00	5	.88
Personal	0	29	3.81	7.76	7	.91
Instrum'tl	0	10	3.41	3.17	4	.58
Health	4	15	9.08	2.82	5	.71
Emotional	5	14	8.61	2.57	5	.78
Moral	5	15	10.71	2.63	5	.75
Protective	3	6	4.11	1.04	3	.58
Burden	6	76	24.41	14.20	22	.89
F. Strain	5	15	8.06	3.00	5	.77
FilialPiety	63	138	92.19	16.22	22	.79
morale	0	15	6.21	3.75	19	.79

*ADL=Activities of daily living, IADL=Instrumental activities of daily living, Personal=Personal Care, Instrumental=Instrumental Care. Health=Health Care, Emotional=Emotional Support, Moral=Moral Support.

4. ANALYSIS OF CARE BEHAVIOR

Research Question 1

To answer research question 1, logistic regression and multiple regression were used. Logistic regression analysis was utilized to examine the relationship between the living arrangements and a set of independent variables (length of residence, working hours, family income, availability of other family caregivers, filial piety of caregivers, and level of dependency of care receivers). The living arrangements variable was dummy coded (living with caregivers=1, not living with=0). Availability of other family caregivers were dichotomous variables (1=if caregivers have one, 0=if not).

Two separate multiple regression analyses were used. One was to examine the relationship between each of the seven care behaviors and the caregivers' socio-demographic variables and filial piety. Another regression analysis was to examine the relationship between the seven care behavior and the disability variables of the care receivers. The seven care behaviors included personal care, instrumental care, health care, emotional support, moral support, protection, and financial support.

The cut-off level of significance for decision making was $p < .10$.

Living Arrangements. Predictors of the older parents' living arrangements were Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). As Table 25 shows, ADL was inversely related to the living arrangements whereas IADL's relationship with the variable was positive. The -2Log Likelihood Chi-square was 27.793 (df 25, $p < .32$).

Availability of caregivers' siblings/siblings-in-law appeared to be an important variable in determining the living arrangements. However, given the small Wald statistic, it

was not significant. 'The Wald statistic has a very undesirable property. When the predictor has a large coefficient, the standard error is large which makes the Wald statistic small (SPSS, 1990)'. After the 'sibling caregiver' variable entered into the model, the ratio of the correct prediction increased from .78 to .86. In the backward stepwise analysis, the 'sibling caregiver' variable entered last and the coefficient was significant at level of $p < .03$.

The results of logistic regression analysis indicates that the elderly's ADL, IADL, and presence of sibling or sibling-in-law caregiver are predictors for the living arrangements. The elderly who have a few limitations in IADL and have more than one adult child caregiver are likely to live with their major caregiver children (Table 25).

Personal Care. The results of the regression analysis for personal care behavior revealed that personal care behavior was not related to any of the caregivers' socio-demographic variables or filial piety. There was no relationship between the level of the older parents' disability and the care behavior.

Instrumental Care. There was a relationship between the instrumental care and some of the caregivers' socio-demographic variables. No relationship was found between the level of elderly's disability and the care behavior.

The strongest predictor for instrumental care was the availability of caregivers' spouses as other caregivers. The t value for the variable was 3.14 at the significance level of $p < .004$. Another strong predictor was the availability of caregivers' siblings as other caregivers. The t value for the variable was 2.32 at the significance level of $p < .03$. No other variable was significantly related to instrumental care. The R square for the instrumental care model was .49. The results of the instrumental regression analysis indicate that caregivers whose spouses and siblings (siblings-in-law) support with caregiving are likely to provide a higher level of instrumental care to their parents/parents-in-law than the caregivers who do not have such helpers.

Table 25. Results of Logistic Regression of Living Arrangements by Caregivers' Socio-demographic Variables and Care Receivers' Dependency.

Independent Var.	<i>B</i>	S.E.	Wald	Sig.
Length of res.	-.1276	.0961	1.7625	ns
Working hours	.0205	.0237	.7493	ns
Family income	-.3014	.2507	1.4456	ns
Caregiver 1	1.3978	1.2112	1.3318	ns
Caregiver 2	1.1699	1.3734	.7256	ns
Caregiver 3	11.7128	49.6812	.0556	*
ADL	-.5126	.2794	3.3675	.07
IADL	.5532	.2896	3.6491	.06
Cognition	.1059	.4345	.0594	ns
Filial piety	-.0828	.0558	2.1991	ns

Note: caregiver 1= availability of caregivers' spouses as other caregivers. caregiver 2= availability of care receivers' spouses as other caregivers. caregiver 3= availability of caregivers' siblings/siblings-in-law as other caregivers.

* Availability of sibling caregiver appeared to be a predictor ($p < .03$).

Health Care. An important variable was the caregivers' length of residence in the U. S.. The length of residence was inversely related to health care. The t value for the variable was -2.31 and it was significant at level of $p < .03$. Availability of care receivers' spouses as caregivers was positively related to health care although the relationship was weak ($t = 1.84$ $p < .08$).

The results of health care regression can be interpreted that the longer the caregivers live in the United States, the less they are likely to provide health care to their ill parents or parents-in-law.

There was no relationship between health care and the disability of the elder care receivers.

Emotional Support. Availability of the caregivers' siblings/siblings-in-law as other caregivers and working hours were strong predictors for the emotional support. The t value for each variable was 2.62 and -2.59 was significant at the $p < .01$ and $p < .02$ level, respectively. The relationship between the 'sibling caregiver' and the emotional support was positive. However, working hours were inversely related to the emotional care. No other variable was statistically significant.

The findings indicate that the caregivers who have siblings as other caregivers are more likely to provide emotional support to their parents. On the other hand, the caregivers who work long hours are likely to spend less time giving emotional support to the parents. Time in the U. S. seems militate against response to the needs of intimate family relationship of the elderly.

Moral Support. The strongest predictor of moral support was availability of caregivers' siblings/siblings-in-law. The t value for the variable was 3.10 and it was significant at the $p < .004$. Other variables which had significant relationships were filial piety and availability of caregivers' spouses as caregivers. The t value for each variable

was 2.21, and 2.1 at the significance level of $p < .04$ and $p < .05$ respectively. The relationships between the three variables and moral support were positive.

The result of moral support regression indicates that filial piety and the availability of the caregivers' siblings and spouses as other caregivers are predictors of moral support by the caregivers. Family income, length of residence, and working hours of the caregivers were not related to moral support.

The findings can be interpreted that the caregivers whose spouses and siblings provide support with caregiving are more likely to provide moral support. At the same time, the more highly caregivers value filial piety, the more likely they are to provide moral support (Table 26).

There was no relationship between moral support and the disability of the elderly.

Protective Care. There was no relationship between protective care and the caregivers' working hours, family income, length of residence, availability of other family caregivers, and filial piety. Disability of the elderly was not related to the protective care either.

Financial Support. None of the caregivers' socio-demographic variables was related to financial support. Neither filial piety of the caregivers nor the disability of the elderly was related to financial support.

Table 26. Results of Multiple Regression of Care Behavior by Caregivers' Socio-demographic Variables and Filial piety

Independent Var.	Dependent Variable			
	Instrumental Care	Health Care	Emotional Support	Moral Support
Working hours	.025	.005	-.048**	-.022
Length of residence	-.036	-.215 **	-.038	.012
Family income	-.121	.023	.0597	-.007
Caregiver 1	3.130***	.951	.041	1.580**
Caregiver 2	-1.871	-1.789	-1.553	-1.364
Caregiver 3	3.087**	2.378*	3.131***	3.127***
Filial piety	-.012	-.032	-.015	.062**
R ²	.49	.36	.38	.57
F	3.441***	2.050*	2.152*	4.686***

Note: Numbers represent multiple regression coefficients. caregiver 1= availability of caregivers' spouses as other caregivers. caregiver 2= availability of care receivers' spouses as other caregivers. caregiver 3= availability of caregivers' siblings/siblings-in-law as other caregivers.

* $p < .1$. ** $p < .05$. *** $p < .01$. one-tailed tests .

As Table 27 indicates, the results of logistic regression and multiple regression indicate that availability of caregivers' siblings and spouses as other caregivers, working hours, and length of residence were related to types of care behavior, and living arrangement, instrumental care, health care, and emotional and moral support. Family income was not related to any type of care behaviors. None of the socio-demographic variables was related to personal care, protective care, and financial support.

Filial piety was related to one type of care behavior, moral support only. Therefore, we can conclude that the impact of socio-demographic variables on care behavior was stronger than the caregivers' filial piety. (Although filial piety was significantly related to moral support, the correlation between the availability of caregivers' siblings/siblings-in-law and moral support was stronger than the correlation between moral support and filial piety.)

Research Question 2

Pearson's product moment correlation was used to answer the research question: whether caregivers' length of residence in the U. S. is related to the utilization of outside help in caring for their frail parents. The correlations indicated that there were no associations between length of residence and utilization of outside help.

Table 27. Relationship between 8 Types of Care Behaviors and Caregivers' Socio-demographic Variables and Filial Piety

Indep. Variable	Dependent Variable							
	Living Arran.	Person'l Care	Instru. Care	Health Care	Emotion Support	Moral Support	Protect Care	Finan. Care
W hrs.					-.**			
L R ¹				-.**				
F I ²								
C 1			+.***		+.***	+.***		
C 2								
C 3	+ *		+.***	+ *	+.***	+.***		
Filial						+.***		
ADL	- *							
IADL	+ *							
Cog. ³								

Note: Direction of relationship is indicated by +(positive) and -(negative). 1= Length of the residence in the United States of caregivers. 2= Caregivers' family income. 3= Cognition of care receivers. C 1 means availability of caregivers' spouses as other caregivers, C2, availability of care receivers' spouses as other caregivers, C3, availability of caregivers' siblings/siblings-in-law as other caregivers.

* $p < .1$. ** $p < .05$. *** $p < .01$. one-tailed tests.

Research Question 3, 4

For the research question regarding caregiver burden, to what extent the characteristics of caregivers and care receivers are related to caregiver burden, two multiple regression analyses were executed.

As Table 28 shows, burden is related to older parents' level of dependency. The activities of daily living (ADL) and instrumental activities of daily living (IADL) were predictors of burden. The t value for ADL and IADL was 2.482 and -1.94 at significance level of $p < .02$ and $p < .06$ respectively. The F value for the model was 2.15 and it was significant at $t < .06$ level. While the relationship between ADL and burden was positive, IADL was inversely related to the burden. In other words, the more the older parents have limits in physical functioning, the more the caregivers perceive a burden. On the other hand, the less the older parents have limits in instrumental activities of daily living, the more the caregivers perceive a burden.

The findings can be explained that when the level of the parents' disability is mild, they are not provided with home care services so that their family members need to provide the services the elderly need. Another explanation may be that the elderly may want to maintain some of the activities they have been involved in prior to the illness and their adult children are not able to assist the older member to fill the gap.

Table 28. Results of Multiple Regression of Caregiver Burden by the Characteristics of Care Receivers

Variable	Beta Coefficient
ADL	3.139**
IADL	-2.032*
Cognitive skill	-.442
Living arrangements	9.158
Parent/in-law	1.550
Sex	5.467
Closeness	-3.425
Caregiver 1	-9.061
Caregiver 2	-7.095
Caregiver 3	-8.309
<i>F</i>	2.154*
<i>R</i> ²	.46

Note: N=36. Closeness= caregivers' feelings of closeness to the care receivers. Caregiver 1= availability of caregiver' spouse as other caregiver. caregiver 2= availability of care receiver's spouse as another caregiver. caregiver 3= availability of caregiver' sibling/singbling-in-law as another caregiver. Living arrangement= whether the care receivers live with the caregivers or not.

* $p < .1$. ** $p < .05$. one-tailed tests.

Research Question 5

The results of regression of family strain reveal that neither the caregivers' family income nor the length of residence in the United States was related with the family strain.

Research Question 6

For the research question concerning the care receivers' morale, two separate multiple regression analyses were utilized. One is to measure the strength of the association between the care receivers' morale and care receivers' dependency (e.g., level of activities of daily living, instrumental activities of daily living, and level of cognitive skills) and the other is between the morale and the types of care behaviors.

Care receivers' disability was strongly related to their morale (see Table 29). However, none of the care behaviors has a relationship with morale. The relationship between the disability variables and morale was statistically significant ($F=4.06$ $p<.009$). Strong predictors were care receivers' activities of daily living(ADL) and instrumental activities of daily living (IADL).

The results of the analyses indicate that frail elderly's morale is determined by the level of their functioning in the areas of the physical and instrumental activities of daily living, not by their adult children's care behavior.

Table 29. Results of Multiple Regression of Care Receivers' Morale by the Level of Disability

Variable	<i>B</i>
ADL ¹	-.548*
IADL ²	.735**
Cognitive skill	-.036
Living arrangements	-.730
<i>F</i>	4.064**
<i>R</i> ²	.34

Note: 1= Activities of daily living. 2= Instrumental activities of daily living.

* $p < .05$. ** $p < .005$. one-tailed tests.

Overall Relationships Between the Characteristics of Caregivers and Care Receivers, and Care Behavior

In order to describe the overall relationships between the characteristics of caregivers and care receivers, and care behavior, canonical correlation analysis was used. The purpose of using canonical correlation analysis was to find out the interrelationships among the sets of dependent and independent variables.

Variables which were found statistically insignificant in the regression analyses were excluded in the canonical correlation analysis. Five dependent variables were entered in the analysis. They are living arrangement, instrumental care, emotional support, moral support and health care. Eight independent variables entered in the analysis include caregivers' working hours, length of their residence in the U. S., availability of other

family caregivers such as caregivers' spouses, care receivers' other adult child and spouses, filial piety.

The canonical correlation analysis extracted five canonical functions. Out of the five, two functions were statistically significant (see Table 30). The first function extracted accounts for the maximum amount of variance on the sets of variables. The second function accounts for the variance not accounted for by the first function. The squared correlation (.64) associated with the first function was statistically significant ($F=1.84$, $df=40/90$, $p<.009$). The squared canonical correlation (.725) associated with the second canonical function was weak ($F=1.49$, $df=28/77$, $p<.086$).

At canonical function one, three dependent variables, moral support, instrumental care, and health care had high structural coefficients which are .87, .80, and .40 respectively (Table 30). The independent variable set (availability of caregivers' spouses and siblings as other caregivers, dependency in activities of daily living, and filial piety) was closely related to the three dependent variables. In other words, these seven variables contribute relatively larger amounts to the shared variance expressed by the squared structural coefficient than do the four independent variables with lower structure coefficients. The four variables are working hours, length of residence, availability of care receiver's spouse as caregiver, and the instrumental activities of daily living (IADL).

For function two, all dependent variables but emotional support were related to the length of residence, filial piety, and IADL. Health care, living arrangement, and instrumental care were inversely related to the length of the residence whereas these care behavior variables were directly related to IADL. Moral support was directly related to the length of residence and filial piety. Moral support also was inversely related to IADL. The results of the two functions are shown in Table 30.

Among the dependent variables, moral support contributed most to the canonical function one with the squared structural coefficient of .75. Other variables relatively

important by their squared structural correlations are instrumental and health care behaviors (.65 and .16 respectively)

In the independent variable set, availability of caregivers' spouses as other caregiver was highly related to the canonical function one with its squared structural coefficient of .55. Availability of the caregivers' siblings as caregivers was also an important variable. The squared structural coefficient was .44. The squared structural coefficients of ADL and filial piety were .21 and .18 respectively (Table 30).

The results of the canonical correlation analysis indicate that availability of alternative caregivers and length of residence in the U. S. affect three types of care behavior (i.e., instrumental care, health care, and moral support). Caregivers who have alternative family caregivers are likely to provide more instrumental help and moral support to their older parents than the caregivers who do not have such relatives. However caregivers who have lived long in the U. S. are likely to provide less health care. These findings are supported by the results of the multiple regression analyses (see Table 26).

Table 30. Coefficients of Canonical Correlation Analysis

	Function 1		Function 2			
Variable	CC	SC	SSC	CC	SC	SSC
Dependent Set						
Living A	-.250	.143	.020	.059	.488	.238
Instru. C	.585	.804	.646	.430	.477	.228
Health C	.101	.403	.162	.675	.758	.575
Emotion S	-.089	.366	.134	-.059	-.010	.000
Moral S	.642	.868	.753	.697	-.365	.133
Adq.	.343			.235		
Redun.	.222			.123		
Independent Set						
W hrs.	-.030	.097	.009	.462	.294	.086
R. years	.134	.074	.005	-.612	-.523	.274
C 1	.601	.738	.545	.316	.017	.000
C 2	-.408	-.220	.048	-.207	-.195	.038
C 3	.488	.663	.440	-.153	.120	.014
Filial Piety	.271	.426	.181	-.544	-.363	.132
ADL	-.019	.462	.213	-.795	.166	.028
IADL	.077	.393	.154	1.075	.420	.176
Adeq.		.200			.094	
Redun.		.129			.049	
C corr.		.804 (p<.009)			.725 (p<.086)	

Note: CC means canonical co-efficient, SC, structural co-efficient, SSC, squared structural co-efficient. Res. means length of residence of caregivers. C1 means availability of caregiver's spouse as other caregiver, C2, availability of care receiver's spouse as other caregiver, C3, availability of caregiver's sibling/sibling-in-law as other caregiver.

CHAPTER IV

SUMMARY AND CONCLUSIONS

1. SUMMARY

This study has attempted to respond to the problem of the paucity of knowledge on the Korean American family's care for the aged relatives. It has attempted to focus on the adult children's care behavior for the framework of caregiving was extended family. How the social norms of extended family and filial obligation change in a new environment has been the main theme of the study.

This study had three objectives. One objective was to describe Korean family caregivers and elderly care receivers. The second objective was to determine the relationship between the caregivers' sociodemographic characteristics and value of filial piety and their care behavior. The third objective was to examine the psychological impact of caregiving on the caregivers and care receivers.

Theory and literature introduced in the first section led to the expectation that the caregivers' socio-demographic characteristics would be associated more with the level of care behavior they provide to frail parents than would their attitude toward filial obligation. Family income and length of residence were particularly suggested as predictors of the family's care behavior. It also was expected that filial piety would be related to emotional and moral support and that these would be related to the level of the elderly's morale. The relationship between characteristics of caregivers and care receivers and caregiver burden were assumed.

The sample consisted of 36 dyads who were Korean American care receivers and their adult children/daughters-in-law caregivers in New York City area. Data were gathered in two structured interviews.

The interpretation of the data is affected by certain limitations of the study. The small sample size and non-random sampling may have obscured some significant relationships.

To respond to the first objective, descriptive information about Korean American adult children and daughter-in-law caregivers and elderly care recipients in the New York City area was provided. The descriptive information may have significance as basic data for Korean American family caregivers of frail older relatives. To respond to the second objective, a theoretical framework for the study was provided and the relationships between the sociodemographic characteristics and types of care behavior were explored by statistical analyses. The third objective was addressed to by the statistical analysis of the relationships between caregiver burden, care receiver morale and care behavior.

The following are the major results of this study.

1. The caregivers, sixteen daughters, 10 sons, and 10 daughters-in-law, varied in the length of residence in the U. S., employment status, family income, household type, and availability of other family caregivers. All but a few were married. The care receivers, 26 female and 10 male, varied in the severity of disability, marital status, living arrangement, and length of residence in the U. S.. The majority of the care receivers were the parents of the caregivers.

In the American families, daughters are the majority of the adult children caregivers (Brody, 1981; Cantor, 1983). Sons appeared to become care providers only when a female siblings were not available (Horowitz, 1985).

In the present study, the majority of the caregivers comes from the son's family. If the elderly do not have a son or the son's family is unable to provide support, their daughter becomes the care provider. One-third of the caregivers provided care within a shared housing. More than half of the caregivers living separately could reach their parents in a half hour. A great majority of them reported frequent telephone contact and visitation.

More caregivers helped with emotional, moral, and financial support than with personal and instrumental care. Female caregivers provided more than sons in areas of house maintenance and providing nutritional food. Sons helped more with transportation than did the daughters.

2. Differences in care behavior level are better predicted by sociodemographic characteristics than cultural factors. Availability of other family caregivers, working hours, and the length of residence are associated with instrumental assistance, health care, emotional and moral support. The caregivers' attitude toward filial piety, however is likely to be positively associated with moral support.

Availability of Other Family Caregivers. Presence of other family caregivers determines the level of the major caregivers' engagement in care behavior. Whether the caregivers' siblings/siblings-in-law help with caregiving is the most important predictor for five types of care behavior; living arrangement, instrumental care, health care, emotional support, and moral support. Whether the caregivers' spouses help with caregiving is associated with instrumental and moral support.

The positive relationship between the presence of other family caregivers and the level of care activities indicate that caring for aged relatives is a collective form of family activity. We may think when caregivers have siblings as helpers, the caregivers' time allocated for caregiving will be reduced because the care tasks are shared. In this study, the caregivers who had siblings/siblings-in-law provided a greater level of care activity. This may be interpreted as family pressure. Especially if the caregivers are thought to have

received more help from their parents than have their siblings, the caregivers may feel obliged to do more than their siblings do for their parents.

Matthews and Rosner(1988) found that the caregiving responsibility for American older parents is shared among the adult children. Gender, geographic proximity, employment and marital status contributed to the styles of siblings' care which range from routine to dissociation. The respondents in the study were sister pair.

In the present study, gender, marital stability, and personal resources influenced the ways in which the siblings participated in caregiving. Female siblings tended to provide help with personal aid and/or cooking more than did the male siblings. Male siblings provided transportation, financial, and protective supports. Siblings who had marital and financial problems were not expected to provide tangible services to their parents.

There were no gender rules when the care task involved more than manual work. Caregivers' siblings/siblings-in-law who had knowledge about social services, law, and English skills often took care of mediating bureaucratic services. Siblings working in medical fields provided assistance with health care.

Many female caregivers reported their husbands as helpers with caregiving in the areas of transportation. Particularly, husbands of the daughters-in-law were indicated more than sons-in-law as the helpers. However, a few male caregivers mentioned their wives as the helpers. In an ideal situation, a daughter-in-law becomes a major caregiver rather than a son. When the son is represented as the caregiver, his wife's participation in the caregiving appeared minimum. This implies that older parents who have sons as their major caregivers may look to other social support networks when they need services with personal aid and housekeeping.

Working Hours. Long working hours explains why caregivers do not provide enough companionship to their older relatives. The negative relation between working hours and the level of emotional support reflect the precedence of practicality over filial obligation. It seems evident that caregivers who work long hours can hardly find time for their parents. For example, one of the caregivers moved to his parents' apartment building after his mother had had a stroke. He wanted to live with his parents but his mother refused this. Although he was cared enough to move near his mother, he could rarely spend time with her because he had to work more than 70 hours a week. Most caregivers made a quick visit to their parents on their way home after work and/or after church on Sunday. Those who shared households with the older relatives did not seem to spend much time with the elderly either because they usually came home late. Lack of time was reported most by the caregivers as the major problem in the caregiving situation.

Employment status of caregivers is one of the determinants of the caregiving hours in studies of American adult children caregivers (Brody & Schoonover, 1986; Cicirelli, 1983; Horowitz, 1985). The gap in care by the children, however, does not seem to fill even after the children become economically stable because the length of residence, which is a predictor of economic status (Hurh and Kim, 1984a) was not positively related to any type of care behavior in the study.

The findings imply that an alternative social support system to the family needs to be developed for the Korean American elderly. Particularly the trend of married women's participation in the labor market and engagement with small business continues to diminish the adult children's ability to provide companionship to their parents.

Length of Residence. The negative relationship between the length of residence of the caregivers in the U. S. and health care can be explained by the elderly's adaptation to the provisions of health care. The years of residence of the elderly was comparable to that of their children. Many of the elderly's health had declined gradually during the long

residence in the U.S. so that they became familiar gradually with the American health system. Eventually their children might not feel obliged to help their parents with health care. Some elderly contacted Korean physicians by themselves. Many were able to manage medication. If they needed other services, home attendants or spouses were available. They accompanied the elderly to the clinics or hospitals in addition to providing assistance with medication and treatment.

The results support the findings of Park(1986) that length of residence of the aged in the U. S., separate household from married children, and high level of service utilization were related to a higher level of cultural adjustment. On the other hand, the negative relationship between the length of residence and health care implies that the caregivers who have lived longest in the U. S. have the most limited roles in providing direct services to their older relatives.

Filial Piety. The positive relationship between filial piety and moral support suggests that filial piety is still a family value among the Korean American adult children who care for their older relatives. The strong attachment to the value is evidenced by the caregivers' motivation of care providing. About a half of them reported moral duty as one of the reasons why they cared for their older relatives.

The caregiver's beliefs about the value of filial piety and great involvement with moral support, however, is not consistent with their engagement with health and emotional care. Furthermore, the high ratio of the utilization of formal care providers contradicts the ideal concept of filial piety. The discrepancy can be explained if we assume they do not practice filial behavior even though they believe in its value. An alternative interpretation is that the meaning of filial responsibility changes.

3. The elderly's physical functioning is predictor of caregiver burden and care receiver morale. The positive relationship between physical functioning and burden indicates that caregivers did not have enough resources to provide personal care services.

Personal care requires day and night involvement. Negotiating time for care often is not possible. This may be why the majority of caregivers who provide personal care were living with older relatives. The relationship between personal care and the living arrangements of the elderly is supported in the logistic regression in the study.

Some siblings/siblings-in-law shared personal care but the assistance was irregular or seasonal. A daughter visited her mother who was living with her brother once a week to give her a bath. Another daughter brought her mother to her house for weeks several times a year to give her sister-in-law living with the mother a break. Another daughter who lived in another state had her vacations at her mother's residence in order to take care of her. The sibling/sibling-in-law would return their home after providing the temporal care. However, the caregiving job is always returned to and stays with the caregivers who live with the older person.

Personal care was perceived as more burdensome than instrumental aid such as shopping and house cleaning in studies of American adult children caregivers (see Hooyman, Gonyea, & Montgomery, 1985).

The negative relationship between the level of the elderly's instrumental activity and caregiver burden may mean that when the elderly's level of instrumental activity function is high, caregivers do not spend much time with them. Therefore, they may feel stressed. Another explanation can be that the older relatives may want to maintain the activities to the level they have had prior to their dependency on children and the caregivers do not have the resources to fill the gap.

The primary determinant of elderly morale is their physical functioning. The findings are consistent with the elderly's attitude toward the disability and their children's care behavior. Loss of control of life was indicated as the most serious problem among the care receivers. The majority reported they were satisfied with the children's care behavior.

2. CONCLUSIONS

The findings lead to the conclusion that for the Korean American families studied, the family caregivers' sociodemographic characteristics are more important than filial piety in predicting the type of care behavior they practice. However, the positive relationship between caregivers' filial piety and their moral support to their parents suggests that the value of filial relations is sustained. The relationships between the elderly's disability and caregiver burden and the elderly's morale reveals a simple fact; when one cannot control one's life because of physical limits, one's mood will go down and the family will feel stress especially when the family is required to fill the gap created by physical limitations.

Based on the findings of the study, the Korean American family's care of older relatives has been modified to fit in to the adult children's immigrant life situation. One of the changes is a decrease in the number of extended households. The majority of the caregivers care for their aged relatives living in separate housing. Once the older parents move of their children's home, the opportunities for having a joint household again seem very limited, particularly after the parents become ill. Only one older person moved in with her unemployed daughter after she became frail.

The utilization of formal support systems and decrease in the daughter-in-law's involvement in care-providing roles are other noticeable changes. Formal social support personnel have substituted for the daughter-in-law or daughter for the 'hands on' services for the disabled elderly. For other basic needs such as income and housing, they depend on the public system.

Sons have emerged as care providers as the daughter-in-law's involvement in caregiving declines. However, this implies a reduction of services in the areas of personal aid and housekeeping. The trend of married women's participation in the labor market,

egalitarianism, economic instability, and presence of the social security system may be some of the factors accounting for changes in the pattern of Korean American family care. Sussman(1976) suggests that because public services provide financial support and health care, the nature of filial responsibility has changed. Children's protective care and emotional support are important in modern society. Korean families surely seem to be moving to the modern concept of filial behavior.

The Korean family no longer takes full responsibility for caring for older relatives. The frail elderly's living separately from their married children, dual career couples, utilization of outside helpers, and the negative relations between working hours and emotional care all imply that without the formal support system, it would not be possible for the elderly to live independently in the community. The implications challenge the common beliefs that the Asian immigrant families have strong family ties and care for their older relatives.

One of the aspects still important in the Korean families is the value of filial responsibility and the extended family evidenced by the positive relationship between availability of other family caregivers and five types of care behavior. Most elderly in the study are cared for by their married son's family, and a great proportion of daughters-in-law are their caregivers. The relationship between filial piety and moral support of the caregivers in the study suggests that older parents have a respected position in the family. The core caregiving of the adult children/daughters-in-law of several households indicates that the extended family is centered on their parents and each child takes his/her share of filial responsibility as a member of the family. Many adult children no longer live with their parents, however their efforts to continue the extended family relations seem evident; some of the efforts include a son's moving in his mother's apartment building, a son's visit to his mother daily, daughters in another state having vacations at their siblings' to care for their parents, and the sibling caregivers' sharing their households with their older

parents for weeks or months a year. The strong family bond will enable their aged relatives to continue to live in the community when the public system supports the family effectively.

3. IMPLICATIONS FOR FUTURE RESEARCH

The findings of the study suggest that the presence of kin helper increases the involvement of the major child caregiver in care activities. Future research should concentrate on the role of kinship in family caregiving to verify the directions of the relationship between the function of kinship and the level of services the family provide to their older relatives.

The findings did not support the hypothesized relationship between family income and care behavior. This may be interpreted to mean that living arrangements and other types of care behavior are not affected by the family's economic resources. Almost all elderly respondents are the recipients of the SSI and medicaid so that their children may be relieved from the financial responsibility. Another implication may be that culture is a more important factor than social class in the family relations.

Because of the lack of information about frail Korean elderly, the non-random sampling procedure was utilized in this study. Therefore, generalization of the findings of the study is limited. Several home care service agencies were approached to obtain the names of Korean elderly but without any result. The Korean community centers for the elderly did not have programs for the disabled elderly. Investigators of Korean American immigrants report the difficulties of obtaining the representative sample. Hurh and Kim (1984a) suggest that the growth of the Korean population in the U. S. and their broad geographical dispersion make the sampling procedure difficult. The high mobility rate of

the Korean family adds to the problem (p.197). The characteristics of Korean immigrants imply that the results of the present study need to be further tested.

The Korean American family's caring for their older parents in small cities or rural area may provide a different picture. Living separately for the elderly may not be as easy as in big cities where Korean communities are established. Korean home attendants may hardly be found in these areas. Investigation of the Korean family in different geographic areas may provide comprehensive information about the families who care for their older parents.

One of the problems during the data collection was time pressure. Particularly, open ended questions often were responded to with a quick statement or responses which did not have any specific point or direction. Rephrasing and asking them to elaborate the statement required time that many care receivers did not have. Well structured interview schedules seem appropriate for further investigation of this group.

Another methodological implication concerns the respondent's privacy. Unlike westerners, Koreans generally are not used to the term 'privacy' in the family context. An individual family member's concern is the whole family concern. Having a separate interview with the elderly or adult children at home was difficult. Segregating the caregiver from the elderly (or vice versa) for the interview seemed to create a situation in which one family member offended the other. Private interviews in a home setting seem to require a sensitive approach.

The results of the study have several implications for social work practice. The caregivers' sharing a house and involvement in various care tasks do not necessarily mean they have supportive of quality relations with their parents. The elderly who reported dissatisfaction with their living arrangement were those who lived with their children. Filial behavior often conflicted with demands at business or home. Particularly, caregivers who helped their older relatives out of duty appeared demoralized by the stress of

caregiving. They reported a much higher level of burden despite their lower level of involvement in caregiving. As Le Vine (1963) suggests, the structure enforcing filial obligation appears to be the source of stress to the caregivers.

One should recognize that Korean American family relations have been shaped by historical and social phenomena in Korea. During the data collection, many respondents illustrated family history and intergenerational relations, which were not included in the study. Although the family functions have been modified, kin relationships are regulated by the concept of the traditional extended family and filial obligation.

The third implication is the awareness of Korean American elderly's loneliness. They lost intimate social relations when they immigrated to the U. S. Being ill and frail limits their social contacts further as they have less interaction with their family members. Their loneliness and isolation are reflected by their response to one of the items of the morale scale. The common response to "whether they get easily angry or upset with" was "I do not have anyone around to get angry with".

The Korean American family's care behavior was influenced by their own culture as well as American culture. The pattern of household and care activities of the adult children's family have changed. The trends of small size of household and egalitarianism will continue to affect the Korean American immigrants' family relations. The adult children caregivers studied are first generation Korean American immigrants. As the generations pass, the acculturation in the family caregiving of older members may increase. To what degree the ideology of extended family and filial obligation will be sustained is a open question.

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APPENDIX

Consent Form

You are being asked to participate in a research study that is looking at how Korean American adult children take care of their parents and how Korean American elderly feel about their adult children's caregiving. This person who will be talking with you is a doctoral student in the College of Social Work at the University of Tennessee. This study is a partial requirement for the investigator's completion of the doctoral program.

Any information you provide during this interview will be kept in strict confidence. The participant's name will not be recognized to anyone. Participation in this study will not affect the benefits you receive from the government or any other programs received by any of your family member. While your participation is very important to understanding Korean American older people and their families, your participation is voluntary. If you wish, you can terminate the interview at any point or refuse to response to the items with which you do not feel comfortable. The entire interview will take a half hour or less. Your candid response to each questionnaire item will be deeply appreciated.

If you have any questions about this study or its findings, you may write or call.

Ja-Won Kim
College of Social Work, 223 Henson Hall
University of Tennessee, Knoxville, Tn. 37996-3333
615-974- 3533

Signature _____

INTERVIEW SCHEDULE I

<< I >>

[A] Caregiver Information.

1. Sex. (Check without asking) 1) F 2) M
2. How are you related to the person for whom you provide care?
 - 1) daughter
 - 2) daughter-in-law
 - 3) son
 - 4) son-in-law
 - 5) spouse of care receiver
 - 6) other (specify) _____
3.
 - 1] How many children does the elderly person have? _____
 - 2] How many of them are in the U.S.?
son _____ daughter _____
4. Where do you or your spouse fall in birth order among your siblings? _____
5. What is your birth date? month _____ year _____ age _____
6. What is your marital status? (Check without asking if known)
 - 1) married 2) single 3) separated 4) divorced 5) widowed
7.
 - 1] How many children do you have? _____
 - 2] How many of them are under 12 years of age? _____
8. How long have you been living in the United States? ____ years
 - 1) 0- 2 years 2) 3-4 years 3) 5-6 years 4) 7- 8 years
 - 5) 9-10 years 6) 11 years and over.
9. How well do you communicate in English?
 - 1] speaking _____ 2] writing _____
 - 1) I don't need help.
 - 2) I need someone to help me sometimes.
 - 3) I need someone to help me frequently.
 - 4) I need someone to help me all the time.

10. How long have you been providing care for your parent?

- 1) 1-12 months 2) 13-24 months 3) 25-36 months 4) 37 months and over

11.

1] Are you working at the present time for pay? 1) yes 2) no.

2] What exactly do you do? _____

3] How many hours do you work a week? _____ hours

- 1) less than 20 hours 2) 21-40 hours 3) more than 40 hours.

12. What is your monthly network income range?

- 1) 0 2) \$ 499 or less 3) \$500-999 4) \$1,000-1,499
5) \$1,500-1,999 6) \$2,000-2,499 7) \$ 2,500 and over

13. How many of your family members work? _____

14.

1] What does the head of your household do? _____

- 1) professional 2) manager, proprietor 3) farmer
4) clerical, sales, technical 5) skilled, foremen 6) semiskilled, operative
7) service worker 8) unskilled 9) farm laborer

2] For whom does he work? 1) Koreans 2) non-Koreans

15. What year of education did the head of your household completed? Write the number of years of completed.

- 1) no schooling 2) elementary school 1-6 3) secondary 7-12
4) some college 5) college 6) post graduate

16. What is the combined monthly net income range of your family ?

- 1) \$999 or less 2) \$1,000 -1,499 3) \$1,500-1,999 4) \$2,000-2,499
5) \$2,500-2,999 6) \$3,000- 3,999 7) \$4,000-4,999 8) \$5,000 and over

17.

1] How many bed rooms does your residence have? _____

2] How many of your family members are living in the residence? _____

18. Who does the housekeeping and cooking? Write 1 for the major worker and 2 for the assistant. (If there is no assistant, do not write 2.)

1] housekeeping 1.____ 2.____ 2] cooking 1.____ 2.____

- 1) myself 2) my spouse 3) parent 4) my children 5) other

19. What is your religion?

- 1) protestant 2) catholic 3) buddism 4) others 5) no religion

20.

1] How is your health? 1) excellent 2) good 3) fair 4) poor

2] Is it alright to ask you what health problem do you have? (If checked 3 or 4)

[B] I would like to ask you about your parent.

1. Sex (check without asking if known) 1) F 2) M

2. How is the elderly person related to you?

1) mother 2) mother-in-law 3) father 4) father-in-law 5) other ____

3. What is the birthdate of the older person? month ____ year ____ age ____

4. What is the marital status of the older person?

1) married 2) single 3) separated 4) divorced 5) widowed

5. What year of education did the older person completed? Write the number of years of completed.

1) no schooling 2) elementary school 1-6 ____
3) secondary 7-12 ____ 4) college/graduate 13 ____

6. How long has she/he been living in the U. S. ____ years

7. How is her/his English proficiency? Which of the following fits most ?

- 1) She/he can carry conversation and obtain information on the phone.
2) She/he can express her/his basic needs.
3) She/he does need helper whenever English language is involved.

8.

1] Where does the elderly person live at the present time? (If she/he is in the hospital, where the person will be living upon the discharge?)

1) with us 2) separate household living alone
3) separate household with other 4) adult home 5) nursing home.

2] (If checked other than 1) How long does it take you to get to your parent's residence from your house? ____ minutes

- 3] Will you tell us why your parent is living separately?
- 9.
- 1] Is she/he working for pay? 1) yes 2) no
- 2] How many hours does she/he work a week?
- 1) less than 20 hours 2) 21-40 hours 3) more than 40 hours.
- 3] What does she/he do?
10. What is your parent's monthly net income range?
- 1) less than \$300 2) \$300-399 3) \$400-599 4) \$600-799
5) \$800-999 6) \$1,000 or more 7) no answer
- 11.
- 1] Does your parent help support you or your family?
- 1) yes 2) no
- 2] In what forms does she/he provide help? (multiple choice is possible)
- 1) housekeeping 2) cooking 3) child care
4) financial support 5) emotional support
6) other _____
- 12.
- 1] Does she/he have a health insurance? 1) yes 2) no
- 2] What insurance she/he have?
- 1) medicaid
2) medicare plan A only
3) medicare plan A and B (hospitalization and doctors' bills)
4) medicaid & medicare B
5) other insurance
- 13.
- 1] Does your parent have any health problem?
- 1) yes 2) no

2] (If checked 1) What health problem does she/he have? Does she / he have any of the following illnesses at the present time? _____

- 1) arthritis or rheumatism 2) high blood pressure 3) heart trouble 4) chronic bronchitis 5) tuberculosis 6) diabetes 7) asthma 8) circulation trouble in arms or legs 9) stomach or intestinal disorders 10) glaucoma 11) kidney disease 12) liver disease
13) illness with bladder 14) pakinson's disease 15) cancer
16) effects of stroke 17) other _____

3] Does she/he have problem with eyesight? (with eyeglasses)

- 1) yes 2) no

4] Does she/he have hearing problem? (without hearing aid)

- 1) yes 2) no

<< II >>

14. Dependency of the Care Receiver

1] Will you check the level of the functioning of your parent in each activity?

A. Toilet

- 1) Cares for self at toilet completely, no incontinence.
2) Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents.
3) Soiling or wetting while asleep more than once a week.
4) Soiling or wetting while awake more than once a week.
5) No control of bowels or bladder.

B. Feeding

- 1) Eats without assistance.
2) Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals.
3) Feeds self with moderate assistance and is untidy.
4) Requires extensive assistance for all meals.
5) Does not feed self at all and resists efforts of others to feed him.

C. Dressing

- 1) Dresses, undresses, and selects clothes from own wardrobe.
2) Dresses, and undresses self with minor assistance.
3) Needs moderate assistance in dressing or selection of clothes.
4) Needs major assistance in dressing, but cooperates with efforts of others to help.
5) Completely unable to dress self and resists efforts of others to help.

D. Grooming (neatness, hair, nails, hands, face, clothing)

- 1) Always neatly dressed, well-groomed, without assistance.
- 2) Grooms self adequately with occasional minor assistance, (shaving).
- 3) Needs moderate and regular assistance or supervision in grooming.
- 4) Needs total grooming care, but can remain well-groomed after help from others.
- 5) Actively negates all efforts of others to maintain grooming.

E. Physical Ambulation

- 1) Goes about grounds or city.
- 2) Ambulates within residence or about one block distant.
- 3) Ambulates with assistance of (check one) 1.() gets in and out without help. 2.() needs help in getting in and out.
a. another person b. railing c. cane d. walker e. wheelchair
- 4) Sits unsupported in chair or wheelchair, but cannot propel self without help.
- 5) Bedridden more than half the time.

F. Bathing

- 1) Bathes self without help.
- 2) Bathes self with help in getting in and out of tub.
- 3) Washes face and hands only, but cannot bathe rest of the body.
- 4) Cannot or will not wash self, but is cooperative with those who bathe him/her.
- 5) Cannot or will not try to wash self, and resists efforts to keep him clean.

2] Instrumental Activities of Daily Living

A. Ability to use telephone

- 1) Operates telephone on own initiative.
- 2) Dials a few memorized numbers.
- 3) Answers telephone but does not dial.
- 4) Does not use telephone at all.

B. Shopping

- 1) Shops alone and returns home independently with purchases.
- 2) Needs to be accompanied on shopping trip.
- 3) Completely unable to shop.

C. Food preparation

- 1) prepares and serves adequate meals independently.
- 2) Prepares adequate meals if supplied with ingredients.

- 3) Heats and serves prepared meals, or prepares meals but does not maintain adequate diet.
- 4) Needs to have meals prepared and served.

D. Housekeeping

- 1) maintains house alone.
- 2) performs light daily tasks such as dish washing, bed-making.
- 3) Performs light daily tasks but cannot maintain acceptable level of cleanliness.
- 4) Needs help with all home maintenance tasks.
- 5) Does not participate in any housekeeping tasks.

E. Laundry

- 1) Does personal laundry completely.
- 2) Launders small items, rinses socks, stockings, etc.
- 3) All laundry done by others.

F. Public transportation

- 1) Travels independently on public transportation.
- 2) Travels on public transportation on certain routes only.
- 3) Use of public transportation limited to taxi cabs.
- 4) Travels only when accompanied by another.
- 5) Cannot travel on public transportation.

G. Responsibility for own medications

- 1) Is responsible for taking medication in correct dosage at correct time.
- 2) Takes responsibility if medication is prepared in advance in separate dosages.
- 3) Is not capable of dispensing own medication.

H. Ability to handle finances

- 1) Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank)
- 2) Manages day-to-day purchases, but needs help with banking, major purchases, etc.
- 3) Incapable of handling money.

3] Cognition

- A. Is your parent forgetful? 1)very much 2)sometimes 3)not at all
- B. Is your parent confused? 1)very much 2)sometimes 3)not at all
- C. Does your parent hear or see things that are not there.
 - 1) very much
 - 2) sometimes
 - 3) not at all

D. Does your parent talk or mumble to her/himself.

1) very much 2) sometimes 3) not at all

E. Does your parent repeat her/himself, telling the same thing over and over.

1) very much 2) sometimes 3) not at all

<< III >>

[A] Caregiver Information

21. Care Behavior

The following are the care tasks you may assist with your parents. Will you identify the care tasks you assist with your parent and check one among the categories of time you spend on per task, and the frequency you provide the tasks.

* How long do you usually spend for the care task?

1) 0 2) 1-19 minutes 3) 20-39 minutes 4) 40-59 minutes
5) 60-89 minutes 6) 90-119 minutes 7) 120 minutes and over

** How often do you involve with the care tasks?

1) less than every week 2) every week 3) every 4-5 days
4) every 2-3 days 5) everyday 6) NA

1] Personal Care

A. Activities of daily living

The following are personal care that older people may need help with. For each, will you tell us the amount of time you spend on and how many times do you help with that?

	1)amount of time	2)frequency
a. eating.	_____	_____
b. getting in an out of bed or chair.	_____	_____
c. dressing.	_____	_____
d. grooming.	_____	_____
e. bathing.	_____	_____
f. getting to or using the toilet.	_____	_____
g. cleaning up after incontinent accidents	_____	_____

B. Instrumental activities of daily living

The following are the housekeeping and transportation tasks you may help with your parent. What amount of time on an average day would you say you spend on each task?

	1)amount of time	2)frequency
a. house cleaning.	_____	_____
b. meal preparation.	_____	_____
c. house maintenance.	_____	_____
d. shopping(groceries & personal items)	_____	_____
e. transportation and escort.	_____	_____

C. Health Care (Circle the most appropriate)

a. How often do you contact the physicians or make an appointment with them upon your parent's request ?

- 0) never
- 1) one or two times out of five requests.
- 2) three or four times out of five requests.
- 3) nearly always whenever requested.

b. When your parent has new prescription of medicine or treatment do you study/obtain information about them?

- 0) never 1) seldom 2) often 3) nearly always

c.

i) Does your parent need assist with taking medication or therapy?
1) Yes 2) No

ii) Do you assist your parent with taking medication or therapy?
1) seldom 2) often 3) nearly always

d. Do you check the safty of the house of your parents regularly? (e.g. check whether there are obstacles for causing falls on the stairs, floors, or bathroom.)

- 0) never 1) seldom 2) often 3) nearly always.

e. Do you assist your parent with her taking a nutritional diet?
0) never 1) seldom 2) often 3) nearly always.

2] Secondary Care

* How often do you or your family perform the following tasks?

A. Bringing reading or recreational materials or gifts to my parents

- 0) never 1) seldom 2) often 3) nearly always.

- B. Taking the elderly to social gatherings and church when there are events
0) never 1) seldom 2) often 3) nearly always.
- C. Having the elderly participate in the family gatherings or outings.
0) never 1) seldom 2) often 3) nearly always.
- D. We regularly spend some time to talk to and listen to our parent so that she/he is not left alone.
0) never 1) seldom 2) often 3) nearly always.
- E. We are with our parent when she/he does not feel good.
0) never 1) seldom 2) often 3) nearly always.
- F. We respect our parent's life experience.
0) do not respect 1) respect a little 2) respect 3) respect to a great deal.
- G. We ask our parent for advise regarding family and other social matters.
0) never 1) seldom 2) often 3) nearly always.
- H. We serve our parent first at meals.
0) never 1) seldom 2) often 3) nearly always.
- I. We show our respect to our parent in social activities.(e.g. We introduce our parent when we are with the people who have not met him/her before. We suggest our parent seat and /or served first at the social activities.)
0) never 1) seldom 2) often 3) nearly always.
- J. When I go shopping or prepare meals for my parent, I try to choose the menu and items that she/he likes.
0) never 1) seldom 2) often 3) nearly always.

3] Protection Care

- A. How much time do you spend for paying the bill and banking a month?
1) 0 2) less than 20 minutes 3) 20-39 minutes
4) 40-59 minutes 5) 60-89 minutes 6) more than 90 minutes

B. How much time do you spend for obtaining information about the benefits and programs for your parent a month?

- 1) 0 2) less than 20 minutes 3) 20-39 minutes
4) 40-59 minutes 5) 60-89 minutes 6) more than 90 minutes

C. How much do you spend time for arranging and supervising the provisions of the informal/formal services for parents a month?

- 1) 0 2) less than 20 minutes 3) 20-39 minutes
4) 40-59 minutes 5) 60-89 minutes 6) more than 90 minutes

D.

a. What proportion of the living expenses of your parent do your family pay?

- 1) 0 2) 25 percent or less 3) 50 percent or less
4) 75 percent or less 5) 100 percent

b. In what areas do you provide financial support to your parent ?
(multiple choices are available)

- 1) pocket money 2) medical bills 3) groceries and personal items
4) housing maintenance and utilities
5) housinbg 6) other _____

22. Following are the persons who may assist with your parent, kinds of services, and the level of services they provide. Will you identify the person and her/his helping behavior as well as the time they spend on it from the following categories. (choose every person who assists with your parent)

* kinds of service: 1) personal care 2) instrumental
 3) emotional/protective care 4) financial support
 5) companionship/sitting.

* frequency: 1) once a month and less 2) 2-3 times a month
 3) every week and less 4) every 4-5 days
 5) every 2-3 days 6) everyday

* amount of time at one visit:

- 1) 30 minutes and less 2) an hour and less 3) an hour and half and less
4) two hours and less 5) 3-4 hour 6) more than five hours.

* caregivers

1] kinds of service 2] frequency 3] hours

spouse of caregiver	_____	_____	_____
spouse of care receiver	_____	_____	_____
children	_____	_____	_____
sister-in-law	_____	_____	_____
sister	_____	_____	_____
nephew or niece	_____	_____	_____
brother-in-law	_____	_____	_____
brother	_____	_____	_____
aunt	_____	_____	_____
other relative	_____	_____	_____
friends/neighbors	_____	_____	_____
paid worker (Korean)	_____	_____	_____
paid worker (non-Korean)	_____	_____	_____
homemaker/nursing	_____	_____	_____

23.

1] How helpful do you think your care tasks in assisting your parent with managing daily living? How effective or adequate do you think you care behavior?

1) not effective 2) effective 3) very effective

2] Why do you think you are ineffective in helping your parent or parent-in-law ?
(If checked 1)

<< IV >>

24. Why are you caring for your parent or parent-in-law? (more than one answer is possible)

- 1) because I am obliged to (or it is my moral duty).
- 2) I love her/him.
- 3) no one else is available
- 4) other _____

25. How comfortable are you with the living arrangement of your parent?

1) not comfortable 2) comfortable 3) extremely comfortable

26. How close do you feel to the care receiver?

0) not close 1) a little 2) close 3) extremely close

27. The following is a list of statements, which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way, never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

- 1] Do you feel that your relative asks for more help than he/she needs?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 2] Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 3] Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 4] Do you feel embarrassed over your relative's behavior?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 5] Do you feel angry when you are around your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 6] Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 7] Are you afraid what the future holds for your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 8] Do you feel your relative is dependent upon you?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 9] Do you feel strained when you are around your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 10] Do you feel your health has suffered because of your involvement with your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always

- 11] Do you feel that you don't have as much privacy as you would like?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 12] Do you feel that your social life has suffered because you are caring for your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 13] Do you feel uncomfortable about having friends over, because of your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 14] Do you feel that your relative seems to expect you to take care of him/her, as if you were the only one he/she could depend on?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 15] Do you feel that you don't have enough money to care for your relative, in addition to the rest of your expenses?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 16] Do you feel that you will be unable to take care of your relative much longer?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 17] Do you feel you have lost control of your life since your relative's illness?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 18] Do you wish you could just leave the care of your relative to someone else?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 19] Do you feel uncertain about what to do about your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 20] Do you feel you should be doing more for your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 21] Do you feel you could do a better job in caring for your relative?
0) never 1) rarely 2) sometimes 3) quite frequently 4) nearly always
- 22] Overall, how burdened do you feel in caring for your relative?
0) not at all 1) a little 2) moderately 3) quite a bit 4) extremely

28. Family Strain

Your family life may be affected by the illness or dependency of your parent. Will you circle the degree of your agreement with your family's experiences in the following areas?

- 1] Because of the illness or dependency of our parent, our household chores are not managed effectively in terms of the cleanliness, meal preparation, and/or children care.

1) not agree 2) agree a little 3) agree 4) strongly agree

- 2] Besides me, other family member does not have enough free time because she/he has to look after our parent.

1) not agree 2) agree a little 3) agree 4) strongly agree

3]

- A. Because of the illness or dependency of our parent, our family is experiencing emotional tensions or conflicts among family members.

1) not agree 2) agree a little 3) agree 4) strongly agree

- B. (If checked 2,3, or 4), Who are involved in the conflicts?

1) myself and parent 2) spouses 3) spouse and parent
4) spouses and children 5) children and our parent.

- 4] Because of the illness or dependency of our parent, our family's social life is affected. (e.g. Our family's outings are restricted.)

1) not agree 2) agree a little 3) agree 4) strongly agree

- 5] Because of the illness or dependency of our parent, my spouse or/and my job are affected.

1) not agree 2) agree a little 3) agree 4) strongly agree

29. The following are the items about filial piety. Will you check one category of the responses that you fit best.

1) strongly disagree 2) disagree 3) mildly disagree
4) mildly agree 5) agree 6) strongly agree

- 1] Sons and daughters may protest against being unreasonably scolded by their parents.

- 2] The best way of teaching people to love one another is to educate them about filial piety.

- 3] If there is a reason for doing so, one may rely on an older people's home to provide for one's aged parents.
- 4] Sons and daughters cannot be expected to sacrifice everything for the sake of their parents' safety.
- 5] Sons and daughters should not go to far away places while their parents are still living.
- 6] In choosing a spouse, sons and daughters need not follow "the parents' command."
- 7] The main reason for sons and daughters not to do dangerous things is to avoid worrying their parents.
- 8] Sons and daughters may continue to do what they are doing if they think that it is reasonable, despite their parents' objections.
- 9] The debt that you have to repay your parents is boundless.
- 10] Sons and daughters do not necessarily have to conduct themselves according to the principles their parents follow.
- 11] No matter how they conduct themselves, sons and daughters must respect their parents.
- 12] "If a child does not end his/her life after being so demanded by one's parents, he/she is unfilial."
- 13] The main reason for children not doing bad things is to avoid damaging their parents' reputation.
- 14] After their parents have passed away, sons and daughters do not necessarily have to tend to the business left unfinished by their parents.
- 15] "Spreading one's fame to glorify one's parents" should not be the most important reason for getting ahead.
- 16] Sons and daughters should worship their deceased parents on the proper occasions in accordance with established custom.
- 17] After the death of one's parents, one should not wear beautiful clothes or eat heartily for some time.
- 18] Even though their parents are still living, sons and daughters do not necessarily have to seek parental advice, and may make their own decisions.
- 19] Sons and daughters do not necessarily have to respect and love the people respected by their parents.

20] After children have grown up, the money they earn through their own labor belongs to themselves, even though their parents are still living.

21] "There is no crime worse than being unfilial."

22] As a son or daughter, one must obey one's parents no matter what.

<< V >>

30.

1] Do you feel rewarded by caring for your parent? 1) no 2) yes

2] How do you think you are rewarded?

31.

1] If your family were in Korea, would your family's care behavior of your parent be different?

1) no

2) Yes

2] How your care behavior would be different in Korea as compared with it here in the United States?

32. Overall, how things are going with caregiving?

33. What are the major problems do you experience in caring for your parents?

34. What are the positive things that you or your family experience in caring for your parents?

INTERVIEW SCHEDULE II

1. Whom do you count on most in caring for you?
1) daughter 2) daughter-in-law 3) son 4) son-in-law 5) grandchildren 6) spouse
7) other relative 8) friend/neighbor 9) other _____
2. Who is the person whom you contact most?
1) daughter 2) daughter-in-law 3) son 4) son-in-law 5) grandchildren 6) spouse
7) other relative 8) friend/neighbor 9) other _____
3. How do you feel close to the person giving you the most care?
1) little or not close 2) close 3) extremely close
4.
 - 1] Do you have friends to whom to talk to when you want to?
1)yes 2)no
 - 2] How many friends do you have _____
 - 3] How often do you see or talk to them? _____
5. How are you satisfied with your living arrangement?
1) not satisfied 2) satisfied 3) very satisfied
6. Are you satisfied with your child or child-in-law's care behavior?
1) not satisfied 2) satisfied 3) extremely satisfied
7.
 - 1] Do you provide help with your child ? 1) yes 2) no
 - 2] In what forms do you help with your child ?
1) housekeeping/child care 2) emotional care
3) financial support 4) other

8. Morale Scale

The following are the items to measure your morale. You are expected to respond "yes" or "no" or ajectives of the questions.

- 1] Things keep getting worse as I get older.
- 2] I have as much pep as I had last year
- 3] How much do you feel lonely? (not much, very much)
- 4] Little things bother me more this year.
- 5] I see enough of my friends and relatives
- 6] As you get older you are less useful.
- 7] I sometimes worry so much that I can't sleep.
- 8] As I get older, things are better or worse than I thought they would be.
(better, worse)
- 9] I sometimes feel that life isn't worth living.
- 10] I am as happy now as when I was younger.
- 11] I have a lot to be sad about.
- 12] I am afraid of a lot of things.
- 13] I get mad more than I used to.
- 14] Life is hard for me much of the time.
- 15] How satisfied are you with your life today? (satisfied, not satisfied)
- 16] I take things hard.
- 17] I get upset easily.

9. The following are the items about filial piety. Will you check one category of the responses that you fit best.

- | | | |
|----------------------|-------------|--------------------|
| 1) strongly disagree | 2) disagree | 3) mildly disagree |
| 4) mildly agree | 5) agree | 6) stronly agree |

- 1] Sons and daughters may protest against being unreasonably scolded by their parents. _____
- 2] The best way of teaching people to love one another is to educate them about filial piety. _____
- 3] If there is a reason for doing so, one may rely on an older people's home to provide for one's aged parents. _____
- 4] Sons and daughters cannot be expected to sacrifice everything for the sake of their parents' safety. _____
- 5] Sons and daughters should not go to far away places while their parents are still living. _____
- 6] In choosing a spouse, sons and daughters need not follow "the parents' command." _____

- 7] The main reason for sons and daughters not to do dangerous things is to avoid worrying their parents. _____
- 8] Sons and daughters may continue to do what they are doing if they think that it is reasonable, despite their parents' objections. _____
- 9] — The debt that you have to repay your parents is boundless. _____
- 10] — Sons and daughters do not necessarily have to conduct themselves according to the principles their parents follow. _____
- 11] No matter how they conduct themselves, sons and daughters must respect their parents. _____
- 12] "If a child does not end his/her life after being so demanded by one's parents, he/she is unfilial." _____
- 13] The main reason for children not doing bad things is to avoid damaging their parents' reputation. _____
- 14] After their parents have passed away, sons and daughters do not necessarily have to tend to the business left unfinished by their parents. _____
- 15] "Spreading one's fame to glorify one's parents" should not be the most important reason for getting ahead. _____
- 16] Sons and daughters should worship their deceased parents on the proper occasions in accordance with established custom. _____
- 17] After the death of one's parents, one should not wear beautiful clothes or eat heartily for some time. _____
- 18] Even though their parents are still living, sons and daughters do not necessarily have to seek parental advice, and may make their own decisions. _____
- 19] Sons and daughters do not necessarily have to respect and love the people respected by their parents. _____
- 20] After children have grown up, the money they earn through their own labor belongs to themselves, even though their parents are still living. _____
- 21] "There is no crime worse than being unfilial." _____
- 22] As a son or daughter, one must obey one's parents no matter what. _____

10. Overall, how things are going with your family?

11. What are the major problems in managing everyday living?

12. What provisions for services or care do you think you need most?

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Ja-won Kim College of Social Work, 223 Henson Hall
University of Tennessee, Knoxville, TN. 37996-3333
615-974-3353

귀하의 서명 _____

12. 귀하의 순수입은? (세금을 제한후)

- 1) 0 2) \$499이하 3) \$500-999 4) \$1,000-1,499
5) \$1,500-1,999 6) \$2,000-2,499 7) \$2,500이상

13. 가족중 몇분이 일하십니까? _____ 명

14. 1] 가장은 어떤일을 하십니까?

- 1) 전문직 2) 매니저, 경영직 3) 농업 4) 사무, 판매, 기술직
5) 숙련공, 실장 6) 반숙련공, 직공 7) 서비스직 8) 비숙련공 9) 농장 노동자

2] 가장 직장의 경영주는? 1) 한국인 2) 비한국인

15. 가장의 교육정도는? (수료하신 학년을 적어주십시오)

- 1) 무학 2) 국민학교 1-6 _____ 년 3) 중고등 학교 7-12 _____ 년
4) 대학 _____ 년 5) 대학원 _____ 년

16. 귀하가정의 월수입은? (세금 제한후)

- 1) \$999이하 2) \$1,000-1,499 3) \$1,500-1,999 4) \$2,000-2,499
5) \$2,500-2,999 6) \$3,000-3,999 7) \$4,000-4,999 8) \$5,000 이상

17. 1] 귀하의 집에는 침실이 몇개 있습니까? _____ 개

2] 이집에 몇분이 사십니까? _____ 명

18. 누가 가사일을 도맡아서 합니까? 맡아서 하는 사람과 도와 주는 사람을 순서대로 적으십시오.

1] 가사 _____ , _____ 2] 요리 _____ , _____

1) 자신 2) 배우자 3) 부/모 4) 자녀 5) 기타

19. 귀하의 종교는?

1) 신교 2) 구교 3) 불교 4) 기타 5) 무교

20. 1] 귀하의 건강상태는?

1) 아주좋다 2) 좋은편이다 3) 그저 그렇다 4) 좋지않다.

2] (위에서 3) 또는 4)를 답한 경우) 어떤 건강 문제를 갖고 있는지 물어도 될까요?

[B] 노인 (부/모) 에 관한 사항

1. 성별은? 1) 여 2) 남
2. 이 노인과 어떤 관계입니까?
- 1) 어머니 2) 시어머니(장모) 3) 아버지 4) 시아버지 5) 기타 _____
3. 노인의 생년월은? _____ 년 _____ 월 _____ 세
4. 노인의 결혼사항은? 1) 결혼 2) 독신 3) 별거 4) 이혼 5) 사별
5. 노인의 교육정도(수료하신 학년을 적으십시오)
- 1) 무학 2) 국민학교 1-6 _____ 년 3) 중고등 학교 7-12 _____ 년
4) 대학 _____ 년 5) 대학원 _____ 년
6. 노인께서 미국에 몇년 사셨습니까? _____ 년 (월)
7. 노인의 영어 구사력은?
- 1) 전화로 통화 할 수 있다. 2) 기본적인 욕구를 영어로 표현 할 수 있다.
3) 영어를 해야할 때마다 누군가의 도움이 필요하다.
8. 1] 노인께서 현재 어디에 사십니까? (현재 입원중이라면 퇴원후 어디에 사실 예정
입니까?)
- 1) 자녀들과 함께 사신다. 2) 혼자 사신다. 3) 다른 사람과 사신다.
4) 구둣호움 또는 노인의 집에 사신다. 5) 양로원에 사신다.
- 2] (위에서 만일 1)번 이외의 답을 했다면) 집에서 부/모님 사시는 곳까지 얼마나
걸립니까? _____ 시간 _____ 분
- 3] 부/모님과 함께 살지 않는 이유를 말씀 해 주실 수 있는지요?
9. 1] 노인께서 일을 하고 계신지요? 1) 예 2) 아니오
- 2] 주 몇시간 일을 하십니까? 1) 20시간 미만 2) 21-39 시간 3) 40시간 이상
- 3] 어떤 일을 하십니까? _____
10. 노인의 월 수입은?(세금을 제한후)
- 1) \$300 이하 2) \$300-499 3) \$500-699 4) \$700-899
5) \$900-1,199 6) \$1,200이상 7) 무응답

11. 1] 노인께서 귀하와 귀하의 가정을 도와주십니까? 1) 예 2) 아니오
- 2] 어떤 도움을 주십니까? (해당하는 사항에 모두 답해주십시오)
- 1) 가사 2) 요리 3) 자녀 보살핌 4) 재정적 보조
5) 심적, 정신적 위안 6) 기타 (구체적으로) _____
12. 1] 노인께서 건강 보험을 갖고 계십니까? 1) 예 2) 아니오
- 2] 어떤 건강 보험을 갖고 계십니까?
- 1)메디케이드 2)메디케어 A 플랜만
3)메디케어 A와 B 플랜(입원 및 의사비) 4)메디케이드와 메디케어 B 플랜
13. 1] 부/모님께서 건강에 문제가 있습니까? 1) 예 2) 아니오
- 2] (위에서 1)에 답한 경우) 노인께서 어떤 병(건강문제)을 갖고 계십니까?
- 1) 관절염, 신경통 2) 고혈압 3) 심장병 4) 만성 기관지염
5) 결핵 6) 당뇨병 7) 천식 8) 혈액 불순환(다리, 팔)
9) 위장염 10) 녹내장 11)신장병 12)간질환
13)방광염 14)파킨슨병 15)암 16)뇌일혈로 인한 장애
17)기타 _____
- 3] 노인의 시력에 문제가 있습니까? (안경을 쓰고) 1) 예 2) 아니오
- 4] 노인의 청각에 문제가 있습니까? (보청기 없이) 1) 예 2) 아니오

<< II >>

14. 노인의 의존도

- 1] 아래에 열거된 여러 일상 활동에서 부/모님의 기능을 평가해 주십시오. 부/모님의 현재 기능이 어디에 해당되는지 적절한 번호에 0표 하십시오

A. 용변

- 1) 스스로 용변을 마칠수 있고 조절 할 수 있다.
2) 용변 보는일을 도와드려야 하고 아주 가끔 용변을 조절못해 실수한다.(많은 주 1회정도)
3) 수면중에 1주 1번 이상 용변을 조절못해 실수하신다.
4) 깨어있는 동안 1주에 1회이상 실수하신다.
5) 전혀 대소변을 조절 못한다.

B. 식사

- 1) 도움없이 식사를 할 수 있다.
2) 스스로 식사하실 수 있지만 식사를 준비하고, 식사 중이나 후에 조금 도움이 필요하다.

- 3) 식사시 다소 도움을 필요로 하고 단정하게 못잡수신다.
- 4) 식사때마다 아주 많은 도움을 필요로 한다.
- 5) 전혀 식사를 혼자 못하시고 도와주는 사람에게 저항한다.

C. 옷입기

- 1) 스스로 자신의 옷을 골라 입고 벗을 수 있다.
- 2) 옷을 입고 벗을때 조금 도움이 필요하다.
- 3) 옷입기와 옷선택할때 다소 도움이 필요하다.
- 4) 옷입고 벗을때 많은 도움이 필요하지만, 옷입기를 도와주는 사람에게 협조한다.
- 5) 전혀 혼자서 옷을 입고 벗을 수 없으며, 옷입기를 도와주는 사람에게 저항한다.

D. 몸치장

- 1) 항상 도움없이 단정하게 옷을 입고 몸단장을 한다.
- 2) 때때로 약간의 도움으로(면도등) 단정함을 유지한다.
- 3) 몸단장에 정기적인 도움과 지시가 필요하다.
- 4) 전적으로 많은 도움이 필요하며, 도움을 받으면 단정함을 유지할 수 있다.
- 5) 몸단장을 도와주는 사람에게 완강히 저항한다.

E. 거동

- 1) 동네나 시내를 외출하실 수 있다.
- 2) 집동네 범위에서 혼자 외출하실 수 있다.
- 3) a.다른사람 b.난간 c.지팡이 d.보행기 e.휠체어)의 도움으로 외출하실 수 있다.
 - 1.() 도움없이 휠체어를 타고 내릴 수 있다.
 - 2.() 휠체어를 타고 내릴때 도움이 필요하다.
- 4) 의자나 휠체어에 앉을 수 있으나 도움 없이는 스스로 휠체어를 움직일 수 없다.
- 5) 침대에 반나절 이상 누워서 지낸다.

F. 목욕

- 1) 도움없이 목욕을 할 수 있다.
- 2) 욕탕에 들어가고 나올 때 도움이 필요하지만 혼자 목욕하실 수 있다.
- 3) 손과 얼굴은 혼자 씻을 수 있지만 그 밖의 신체부분은 혼자 씻을수 없다.
- 4) 스스로 씻을 수 없으나 목욕시켜주는 사람에게 협조적이다.
- 5) 스스로 목욕할 수 없고 씻고자 하지도 않고, 씻어주는 사람에게 저항하신다.

2] 일상생활에 필요한 기능들

A. 전화 사용 능력

- 1) 스스로 전화를 걸 수 있다.
- 2) 몇몇 기억하는 전화번호만 돌릴 수 있다.
- 3) 오는 전화를 받을 수 있지만 전화를 걸지는 못하신다.
- 4) 전혀 전화를 사용 못하신다.

B. 쇼핑 (장보기)

- 1) 혼자 물건을 살 수 있고, 사신 물건을 가지고 집에 돌아오실 수 있다.
- 2) 물건을 사러 나갈때 누가 같이 가야 한다.
- 3) 전혀 물건을 사러 나가실 수 없다.

C. 식사준비

- 1) 혼자 적절하게 음식을 장만하고 식사를 준비할 수 있다.
- 2) 재료를 준비해 드리면 적절히 식사를 준비할 수 있다.
- 3) 준비된 음식을 데우고 식탁을 차릴 수 있으며, 식사를 준비할 수는 있지만 영양식을 지속하시지 못한다.
- 4) 누군가가 조리해서 식탁을 차려드려야 한다.

D. 살림 (가사일)

- 1) 살림을 혼자 꾸러 나갈 수 있다.
- 2) 설건이나 잡자리 준비등 가벼운 일상적인 가사일을 할 수 있다.
- 3) 가벼운 일상적인 살림살이를 할 수는 있지만, 청결하게 못하신다.
- 4) 모든 가정사를 처리함에 있어 도움이 필요하다.
- 5) 아무 가사일도 할 수 없다.

E. 세탁

- 1) 자신의 세탁을 완벽하게 하신다.
- 2) 작은 빨래나 양말 등을 빨 수 있다.
- 3) 모든 빨래를 남이 해야 한다.

F. 공공 교통 수단

- 1) 외출시 대중 교통수단을 이용할 수 있다.
- 2) 특정 노선에 한하여 공공 교통 수단을 이용할 수 있다.
- 3) 공공 교통 수단으로는 택시로만 외출이 가능하다.
- 4) 누가 동행을 해야 외출이 가능하다.
- 5) 전혀 공공 교통 수단을 이용할 수 없다.

G. 약복용

- 1) 혼자 시간에 맞추어 적량의 약을 복용할 수 있다.
- 2) 사전에 복용할 약이 준비되면 약을 복용할 수 있다.
- 3) 혼자 약을 복용할 수 없다

H. 재정관리

- 1) 스스로 재정을 관리할 수 있다. (예산을 세우고 수표를 쓰고, 은행에 가고 공과금과 집세를 낼 수 있다.)
- 2) 일상 소모품을 혼자 구매할 수 있지만, 은행일이나 주요한 물품 구매시에는 도움이 필요하다.
- 3) 돈을 관리할 수 없다.

3] 인지력

A. 노인께서 자주 잊으십니까? (전망중)

- 1) 아주 빈번하게 2) 때때로 3) 전혀 그렇지 않다

B. 노인께서 혼동을 일으키십니까?

- 1) 아주 빈번하게 2) 때때로 3) 전혀 그렇지 않다

C. 주변에 없는 사물을 보거나 들으십니까?

- 1) 아주 빈번하게 2) 때때로 3) 전혀 그렇지 않다

D. 혼잣말을 하거나 중얼거립니까?

- 1) 아주 빈번하게 2) 때때로 3) 전혀 그렇지 않다

E. 하신 말씀을 자주 반복 하십니까?

- 1) 아주 빈번하게 2) 때때로 3) 전혀 그렇지 않다

<< III >>

[A] 돌보는 사람에 대한 사항

21. 돌보아 드리는 일들

다음은 노인을 보살피는 일에 관한 것입니다. 귀하는 어떤 일로 노인을 돌보시는지요? 도움을 주는 일에 체크하시고, 그일에 할애하는 시간과 빈도를 아래의 보기에서 골라 답하십시오.

* 소요시간

- 1) 0 2) 1-19분 3) 20-39분 4) 40-59분 5) 60-89분 6) 90-119분 7) 120분 이상

** 빈도

- 1) 주 1회 미만 2) 주 1회 정도 3) 4-5 일에 한번
4) 2-3 일에 한번 5) 매일 6) 관련 없음

1] 신체 간호

A. 일상적 활동

다음은 귀하가 노인께 드리는 신체 간호에 관한 일들입니다. 도움을 드리는 일에 체크하시고 시간과 빈도를 위 보기에서 고르십시오.

1) 도와 드림 2) 소모시간 3) 빈도

- | | | | |
|----------------------|-------|-------|-------|
| a. 식사 | _____ | _____ | _____ |
| b. 침대나 의자에 앉고 일어나기 | _____ | _____ | _____ |
| c. 옷입기 | _____ | _____ | _____ |
| d. 몸단장 | _____ | _____ | _____ |
| e. 목욕 | _____ | _____ | _____ |
| f. 화장실에 가고 용변 보는일 | _____ | _____ | _____ |
| g. 용변을 실수 하셨을때 뒤통리 일 | _____ | _____ | _____ |

B. 일상생활에 필요한 기능들

다음은 귀하가 노인께 도움을 드리는 가사일과 교통편 제공에 대한 일들입니다. 도움을 드리는 일에 체크하시고 시간과 빈도를 위 보기에서 고르십시오.

1) 도와 드림 2) 소모시간 3) 빈도

- | | | | |
|--------------------|-------|-------|-------|
| a. 집청소 | _____ | _____ | _____ |
| b. 식사준비 | _____ | _____ | _____ |
| c. 집관리 | _____ | _____ | _____ |
| d. 장보기 (찬거리, 개인용품) | _____ | _____ | _____ |
| e. 교통수단 제공 및 동행 | _____ | _____ | _____ |

C. 건강관리 (가장 적절한 답에 0표를 하십시오)

- a. 얼마나 자주 노인의 요청에 따라 의사를 보도록 연락을 취합니까?

1) 5번 청하면 1-2번 정도 2) 5번 청하면 3-4번 정도 3) 거의 언제나

- b. 부/모님(노인)께서 약처방이나 치료를 받을때 그에관한 정보를 알아보거나 요구합니까?

1) 거의 안한다 2) 자주 3) 거의 언제나

- c. i) 노인께서 약을 드시거나 치료를 받을때 도움이 필요 합니까? 1)예 2)아니오

ii)귀하는 노인께서 약을 드시거나 치료를 받으실때 돕습니까?

1) 거의 안한다. 2) 자주 3) 거의 언제나

- d. 정기적으로 노인이 사시는 곳의 안전을 점검합니까? (층계, 마루, 목욕실에 위험한 걸림물이 있는지 조사)

1) 거의 안한다 2) 자주 3) 거의 언제나

- e. 귀하는 노인께서 영양이 고루 갖추어진 식사를 하시도록 도와 드립니까?

1) 거의 안한다 2) 자주 3) 거의 언제나

2) 2차적인 간호

*얼마나 자주 귀하나 가족들이 다음의 일들을 합니까?

A. 입을거리나 오락거리를 노인께 가져다 드린다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

B. 노인을 사람들이 모이는 곳이나 교회에 일이 있을때 모시고 간다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

C. 노인을 가족모임이나 외출시 함께 모신다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

D. 노인께서 외로와 하지 않도록 말을 걸거나 하시는 말씀을 들어 드린다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

E. 심기가 좋지 않을때 노인과 함께 있다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

F. 노인의 인생경험을 존중해 드린다.

- 1) 존중하지 않는다 2) 존중한다 3) 아주 많이 존중한다

G. 가정사나 다른 공사에 관해 부모님의 조언을 구한다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

H. 식사를 들때마다 늘 부모님을 먼저 드린다.

- 1) 거의 안한다 2) 자주 3) 언제나

I. 사회생활에서 부/모님께 존경을 표시한다.(사람들에게 소개해 드리고, 부/모님께 자리를 먼저 권하고, 부모를 우선으로 한다.)

- 1) 그렇지 않다 2) 자주 3) 거의 언제나

J. 장에 가거나 식사를 준비할때 부/모님께서 좋아 하시는 물건이나 음식을 고르려고 한다.

- 1) 거의 안한다 2) 자주 3) 거의 언제나

3] 보호 및 보살피는 일

A. 한달에 얼마나 많은 시간을 부모님 대신 공과금을 내고 은행에 가는데 소모합니까?

- 1) 0 2) 20분 미만 3) 20-39분 4) 40-59분 5) 60-89분 6) 90분 이상

B. 한달에 얼마나 많은 시간을 부/모님이 참여하실 수 있는 프로그램이나 받으실 수 있는 혜택에 대한 정보를 구하는 일에 소모하십니까?

- 1) 0 2) 20분 미만 3) 20-39분 4) 40-59분 5) 60-89분 6) 90분 이상

C. 얼마의 시간을 부/모님이 필요한 공공 프로그램이나 돌보는 사람을 주선하고 관리 하는데 소모하십니까?

- 1) 0 2) 20분 미만 3) 20-39분 4) 40-59분 5) 60-89분 6) 90분 이상

D. a. 부/모님의 생활비중 몇 퍼센트를 귀하의 가족이 부담하십니까?

- 1) 0 2) 25% 이하 3) 50% 이하 4) 75% 이하 5) 100%

b. 어떤면에서 부/모님께 경제적인 도움을 드립니까?

- | | | |
|--------------|--------|---------------|
| 1) 용돈 | 2) 의료비 | 3) 찬거리 및 개인용품 |
| 4) 집관리비와 공과금 | 5) 집세 | 6) 기타 _____ |

22. 다음은 귀하의 부모님을 도와주는 사람들과 그들이 하는 일에 관한 사항입니다. 노인을 돌보는 분을 밝혀 주시고, 돌보는 일, 빈도, 일에 소모하는 시간을 응답 범주에서 선택하십시오.

* 돕는일 1) 신체 간호 2) 기능적 보살핌 3) 정신위안 및 보호
 4) 재정 보조 5) 친구역할

* 빈도 1) 1달에 1번 또는 그 이하 2) 1달에 2-3 번 3) 매주 4) 4-5 일 5) 매일

* 한 번 방문시 소모하는 시간

- | | | |
|-----------|--------------|------------|
| 1) 30분 이하 | 2) 1시간 이하 | 3) 1시간반 이하 |
| 4) 2시간 이하 | 5) 3-4 시간 이하 | 6) 5시간 이상 |

** 돕는 사람

1] 돕는일

3] 빈도

4] 시간

배우자

노인의 배우자

자녀

시누이(올케)

여자 형제

조카

매형/부 형제남편

남자 형제

고모/이모

다른친척 _____

친구 및 이웃 _____

고용 간호인(한국인)

고용 간호인(비한국인)

23. 1] 귀하의 보살핌이 부/모님이 일상생활을 해나가시는데 얼마나 효과적이라고 생각하십니까?

1) 효과적이지 못하다

2) 효과적이다

3) 매우 효과적이다

2] (위에서 1)번에 답한 경우) 귀하가 노인을 돕는일이 왜 비효과적이라고 생각하십니까?

<< IV >>

24. 왜 부/모님을 돌보아 드리십니까? (해당사항에 모두 답하십시오).

1) 본인이 해야만 하는 일이므로(도덕적 의무)

2) 그분을 사랑하기 때문에

3) 본인 이외에 돌보아 드릴 사람이 없으므로

4) 기타 (구체적으로) _____

25. 부/모님의 주거사항에 대해 편안하게 느끼십니까?

1) 편안하게 느끼지 않는다.

2) 편안하게 느낀다.

3) 아주 편안하게 느낀다.

26. 보살피는 분에 대해 가깝게 느끼십니까?

1) 조금 가깝게 느낀다.

2) 가깝게 느낀다.

3) 아주 가깝게 느낀다.

27. 다음은 노인을 간호하는 사람들이 느끼는 여러가지 감정 및 생각에 대한 것입니다. 각 문장을 읽으시고 귀하가 얼마나 자주 그렇게 느끼시는지 하나를 선택하십시오. 옳고 그른 대답은 없습니다.

1] 귀하는 노인분이 필요 이상으로 도움을 요청한다고 느끼십니까?

0) 전혀 안그렇다

1) 아주 드물게

2) 때때로

3) 자주

4) 거의 늘

- 2] 노인을 돌보기 때문에 귀하자신을 위한 시간을 충분히 갖지 못한다고 생각하십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 3] 노인분을 돌보시면서 가족과 직장 일에 대한 책임을 해야 하기때문에 스트레스를 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 4] 노인분의 행동때문에 당혹감을 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 5] 노인이 주변에 같이 있을때 화가 납니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 6] 현재 돌보시는 노인분 때문에 다른 가족이나 친지와의 관계가 부정적인 영향을 받고 있다고 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 7] 노인분의 미래에 대해 두려우십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 8] 노인분이 귀하에게 의존하고 있다고 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 9] 노인분이 곁에 있을때 긴장감을 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 10] 노인을 돌보기 때문에 귀하의 건강이 나빠졌다고 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 11] 귀하가 원하는 만큼의 사생활을 못갖는다고 생각하십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘
- 12] 귀하가 노인을 돌보는 일때문에 귀하 자신의 사회생활이 지장받고 있다고 느끼십니까?
- 0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

13] 노인을 돌보는 일 때문에 친구를 집에 불러 오게 하는것이 불편하다고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

14] 노인께서 귀하밖에는 의지할 분이 없는것 처럼 귀하가 전적으로 돌보아줄 것을 기대하신다고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

15] 귀하는 다른 지출도 많은데 노인을 돌볼만한 충분한 돈이 없다고 생각하십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

16] 귀하는 노인분을 더이상 돌보아 드릴 수 없을 것이라고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

17] 노인께서 편찮으신 이래 귀하 자신의 생활을 조절할 수 없게되었다고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

18] 노인을 돌보는 일을 다른사람에게 맡겼으면 하고 바라십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

19] 노인분을 어떻게 해야 할지 모르겠다고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

20] 노인을 위해 뭔가 더 해드려야 한다고 생각 하십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

21] 노인을 좀 더 잘 보살펴 드릴 수 있다고 느끼십니까?

0) 전혀 안그렇다 1) 아주 드물게 2) 때때로 3) 자주 4) 거의 늘

22] 전반적으로, 노인을 돌보는 일이 얼마나 부담스럽게 느껴지십니까?

0) 전혀 부담스럽지 않다. 1) 조금 2) 꽤 부담스럽다
3) 많이 부담스럽다. 4) 아주 많이 부담스럽다.

28. 가족간의 긴장감 및 피로

다음 각문장은 귀하의 가족들이 부/모님의 병환과 의존성 때문에 가족들이 경험할 수 있는 일들입니다. 해당 답에 0포 하십시오.

- 1] 부/모님의 병환및 부양의 필요성으로 인하여 집안 청소, 식사준비, 육아등 가사일이 효과적으로 처리되지 않는다.

1) 불찬성 2) 다소 찬성 3) 찬성 4) 아주 찬성

- 2] 나쁜 아니라, 다른가족들도 부/모님을 돌보는 일 때문에 충분히 자유시간을 갖지 못한다.

1) 불찬성 2) 다소 찬성 3) 찬성 4) 아주 찬성

- 3] A. 노인의 병환 및 의존성 때문에 우리 가족들의 감정이 고조되고 서로 갈등 느낀다.

1) 불찬성 2) 다소 찬성 3) 찬성 4) 아주 찬성

- B. (위에서 2),3),4)를 답한 경우) 누구와 갈등을 느끼는지요?

1) 나와 부/모 2) 우리 부부 3) 나의 배우자와 부/모
4) 부부와 자녀 5) 자녀와 부/모

- 4] 노인의 병환및 의존성 때문에 우리 가족의 사회생활에 지장이 있다. (외식과 나들이에 제한을 받는다)

1) 불찬성 2) 다소 찬성 3) 찬성 4) 아주 찬성

- 5] 부/모님의 병환 및 의존성 때문에 직장생활이 영향 받고 있다.

1) 불찬성 2) 다소 찬성 3) 찬성 4) 아주 찬성

29. 다음은 효도에 관한 사항입니다. 각문장을 읽으시고 귀하가 가장 적절하다고 생각하는 답을 아래 보기에서 골라 해당 번호를 각 문장 끝에 적어 주십시오.

1) 아주 불찬성 2) 불찬성 3) 다소 불찬성
4) 다소 찬성 5) 찬성 6) 아주 찬성

- 1] 아들, 딸은 그들의 부모가 불합리하게 야단칠때 항의할 수 있다. ____
- 2] 서로 사랑하라고 가르치는 가장 좋은 방법은 효도에 관해 가르치는 것이다. ____
- 3] 정당한 사유만 있다면 노부모 보살핌을 양로원에 위탁해도 된다. ____
- 4] 아들과 딸에 대해 부모의 안전을 위해 무엇이든 다 희생하도록 기대할 수 없다. ____
- 5] 아들과 딸은 부모 생존시, 먼곳으로 가서는 않된다. ____
- 6] 배우자 선택시, 자녀는 부모의 지시를 따라야할 필요가 없다. ____
- 7] 자녀가 위험한 일을 하지 말아야 하는 가장 큰 이유는 부모님께 걱정을 끼치지 않기 위해서이다. ____

- 8] 부모가 반대하여도 아들, 딸들은 자기들이 합당한 일이라고 생각하면 계속해도 된다. ____
- 9] 부모님께 갚아야 할 은혜는 끝이 없다. ____
- 10] 자녀들은 부모가 따르는 원칙에 따라서 반드시 행동할 필요는 없다. ____
- 11] 부모의 행동이 어떻든간에, 자식들은 부모를 존경해야 한다. ____
- 12] 자녀가 부모의 요구를 받고도 처신을 고치지 않으면 불효하는 것이다. ____
- 13] 자녀가 나쁜일을 하지 말아야 하는 가장 큰 이유는 부모의 이름을 더럽히지 말아야 하기 때문이다. ____
- 14] 부모가 돌아가신 후 자녀들은 반드시 부모가 남긴 일을 떠맡아야 할 필요가 없다. ____
- 15] “부모를 영예롭게 하기위해 명성을 떨치는 것”이 출세의 가장 큰 이유가 되어서는 안된다. ____
- 16] 자녀는 관례에 따라 돌아가신 부모님께 제사를 드려야 한다. ____
- 17] 부모가 돌아가신 후 얼마동안은 화려한 옷을 입거나 맛있는 음식을 맘껏 먹어서는 안된다. ____
- 18] 부모가 생존해 계셔도 자녀는 반드시 부모의 충고를 따를 필요가 없고 스스로 결정을 할 수 있다. ____
- 19] 자녀는 부모가 존경하는 사람들을 반드시 존경하거나 사랑할 필요는 없다. ____
- 20] 자녀가 성인이 된 후 노력을 해서 번 돈은 부모가 생존해 계셔도 자녀의 것이다. ____
- 21] 불효보다 더 큰죄는 없다. ____
- 22] 자식된 도리로써 자녀는 부모에게 복종해야 한다. ____

<< V >>

30. 1] 부/모님을 돌보아 드림으로써 보람을 느끼십니까? 1) 예 2) 아니오
 2] 어떻게 (어떤면에서) 보람을 느끼고 계십니까?

31. 1] 만일 귀하의 가족이 한국에 있다면 부/모님에 대한 보살핌이 지금과 다를것이라고 생각 하십니까?
 1) 예 2) 아니오

2] 어떻게 한국에서 돌보는 것과 다르리라고 생각하십니까?

32. 전반적으로 볼 때, 부/모님을 보살피는 일이 어떻게 잘 되어갑니까? (별 문제가 없으신지요?)

33. 부/모님을 돌보시는데 문제가 있다면 어떤 문제인지 말씀해 주십시오.

34. 부/모님을 돌보시면서 귀하나 귀하의 가족이 경험한 일 중에서 긍정적인 측면을 말씀해 주십시오.

면담 설문지 2

1. 보살핌을 받으심에 있어 누구에게 가장 의지합니까?
 1) 딸 2) 며느리 3) 아들 4) 사위 5) 손녀, 손자
 6) 배우자 7) 다른 친척 8) 친구, 이웃 9) 기타 _____
2. 누구와 가장 많은 연락을 취하고 있습니까?
 1) 딸 2) 며느리 3) 아들 4) 사위 5) 손녀, 손자
 6) 배우자 7) 다른 친척 8) 친구, 이웃 9) 기타 _____
3. 귀하를 가장 많이 돌봐 드리는 분에 대해 얼마나 가깝게 느끼십니까?
 1) 전혀 가깝게 느끼지 않는다. 2) 가깝게 느낀다. 3) 아주 가깝게 느낀다.
4. 1] 귀하께서 원하실때 함께 이야기를 나눌 친구분이 있습니까? 1) 예 2) 아니오
 2] 친구분이 얼마나 많으신지요? _____ 명
 3] 얼마나 자주 그분들과 이야기를 나누십니까? _____
5. 현재의 주거 방식에 만족하십니까? 1) 불만족 2) 만족 3) 아주 만족
6. 귀하의 자녀나 며느리의 보살핌에 만족하고 계십니까? 1)불만족 2)만족 3)아주 만족
7. 1] 귀하의 자녀들에게 도움을 주고 계십니까? 1) 예 2) 아니오
 2] 어떤 도움을 주십니까?
 1) 가사및 육아 (어린이 보살핌) 2) 심적(정신적으로) 지원, 위안
 3) 재정적 도움 4) 기타 _____
8. 다음은 귀하의 사기를 측정하기 위한 것입니다. 각 문항을 읽으시고, 예/아니오, 또는 적절한 보기를 골라 주십시오.
 1] 나이가 들어감에 따라 일들이 악화되어 간다. 예, 아니오
 2] 작년 만큼의 기력을 지금도 지니고 있다. 예, 아니오
 3] 얼마나 외롭다고 느끼십니까? 별로, 많이
 4] 올해는 사소한 일들이 신경을 건드린다. 예, 아니오
 5] 충분한 수의 친구와 친척을 만난다. 예, 아니오
 6] 나이가 들어감에 따라 쓸모가 없어진다. 예, 아니오
 7] 때때로 너무 걱정이 많아서 잠을 잘 수 없다. 예, 아니오

- 8] 나이가 들수록 생각했던것 보다 일이 더 악화된다, 좋아진다.
- 9] 때때로 인생이 살 가치가 없는 것처럼 여겨진다. 예, 아니오
- 10] 젊었을때 만큼이나 지금도 행복하다. 예, 아니오
- 11] 슬퍼해야 할 일이 많다. 예, 아니오
- 12] 여러가지 일들이 두렵다. 예, 아니오
- 13] 예전보다 화를 더 잘낸다 예, 아니오
- 14] 대부분의 경우 나에게서는 인생이 고달프다. 예, 아니오
- 15] 요즘 귀하의 생활에 얼마나 만족하십니까? 만족, 불만족
- 16] 상처를 쉽게 받는다.(쉽게 섭섭해 한다) 예, 아니오
- 17] 쉽게 짜증이 난다. 예, 아니오
9. 다음은 효도에 관한 사항입니다. 각 문장을 읽으시고 귀하께서 가장 적합하다고 생각 하는 답을 응답 범주에서 고르십시오.

- | | | |
|-----------|--------|-----------|
| 1) 아주 불찬성 | 2) 불찬성 | 3) 다소 불찬성 |
| 4) 다소 찬성 | 5) 찬성 | 6) 아주 찬성 |

- 1] 아들, 딸은 그들의 부모가 불합리하게 야단칠때 항의 할수 있다. ____
- 2] 서로 사랑하라고 가르치는 가장 좋은 방법은 효도에 관해 가르치는 것이다. ____
- 3] 정당한 사유만 있다면 노부모 보살핌을 앙로원에 의탁해도 된다. ____
- 4] 아들과 딸에 대해 부모의 안전을 위해 무엇이나 다 희생하도록 기대할 수 없다. ____
- 5] 아들과 딸은 부모 생존시, 먼곳으로 가서는 않된다. ____
- 6] 배우자 선택시, 자녀는 부모의 지시를 따라야할 필요가 없다. ____
- 7] 자녀가 위험한 일을 하지 말아야 하는 가장 큰 이유는 부모님께 걱정을 끼치지 않기 위해서이다. ____
- 8] 부모가 반대하여도 아들, 딸들은 자기들이 합당한 일이라고 생각하면 계속해도 된다. ____
- 9] 부모님께 갚아야 할 은혜는 끝이 없다. ____
- 10] 자녀들은 부모가 따르는 원칙에 따라서 반드시 행동할 필요는 없다. ____
- 11] 부모의 행동이 어떻든간에, 자식들은 부모를 존경해야 한다. ____

- 12] 자녀가 부모의 요구를 받고도 처신을 고치지 않으면 불효하는 것이다. ____
 - 13] 자녀가 나쁜일을 하지 말아야 하는 가장 큰 이유는 부모의 이름을 더럽히지 말아야 하기 때문이다. ____
 - 14] 부모가 돌아가신 후 자녀들은 반드시 부모가 남긴 일을 떠맡아야 할 필요가 없다. ____
 - 15] “부모를 영예롭게 하기위해 명성을 떨치는 것”이 출세의 가장 큰 이유가 되어서는 안된다. ____
 - 16] 자녀는 관례에 따라 돌아가신 부모님께 제사를 드려야 한다. ____
 - 17] 부모가 돌아가신 후 얼마동안은 화려한 옷을 입거나 맛있는 음식을 맘껏 먹어서는 안된다. ____
 - 18] 부모가 생존해 계셔도 자녀는 반드시 부모의 충고를 따를 필요가 없고 스스로 결정을 할수있다. ____
 - 19] 자녀는 부모가 존경하는 사람들을 반드시 존경하거나 사랑할 필요는 없다. ____
 - 20] 자녀가 성인이 된 후 노력을 해서 번 돈은 부모가 생존해 계셔도 자녀의 것이다. ____
 - 21] 불효보다 더 큰죄는 없다. ____
 - 22] 자식된 도리로써 자녀는 부모에게 복종해야 한다. ____
10. 가족간에 별 문제가 없으신지요?

11. 일상 생활에 있어 특별히 어려운 점은 무엇입니까?

12. 가장 필요로하시는 서비스나 도움은 어떤 것들입니까?

VITA

Ja-Won Kim was born in Seoul, Korea, on July 17, 1947. She received a Bachelor of Arts degree in English in 1969 from Song Shim Women's College in Korea. After working for 5 years as an English teacher and translator in Korea, she entered the Graduate School of the State University of New York, Stony Brook where she received a Master degree in Social Welfare in 1977.

Ms. Kim worked at the Rehabilitation Center for the Disabled for three years as a social worker and then director of the planning department. During the year of 1983 and 1984, she was an instructor in social work at the Soong Jeon University and Kang Nam School of Social Welfare, Korea. She entered the Graduate School at the University of Tennessee in September 1986 and received the Doctor of Philosophy in August 1992.