

## The Physical & Psychosocial Functioning of Korean Immigrant Elderly in Northwest America

Yeon-Hee Choi

*Dept. of Nursing Kyungsan University, Daegu, Korea*

〈CONTENTS〉

|                 |                |
|-----------------|----------------|
| ABSTRACT        | III. RESULTS   |
| I. INTRODUCTION | IV. DISCUSSION |
| II. METHOD      | REFERENCES     |

### ABSTRACT

The growing population of the elderly who have diverse health needs is receiving more attention from the health promotion field. This paper describes some of the findings of quantitative study into the health function of Korean immigrant elderly living in Washington State of Northwest America. One hundred-two community-dwelling Korean immigrant elderly, aged from 65 to 93 with a mean 77.97 years, were interviewed with a structured questionnaire to report their health function defined in three domains; perceived health status, physical functioning, and psychosocial functioning.

The main results of the study were identified: (a) Overall, Korean immigrant elderly's perceived health status and physical functioning were good, but psychosocial functioning was poor; (b) Elderly with higher health functioning scores perceived better health status. Data indicates that health functioning measures are good indicators of the degree of perceived need for immigrant elderly. The paper argues that the understanding of physical and psychosocial functioning of elderly is vitally important in the provision of health care.

*Key words* : Korean immigrant elderly, Physical functioning, Psychosocial functioning

## I. INTRODUCTION

As human life expectancy has extended, the global population of the elderly has continually increased, showing the fastest growing rate among all age groups. By the year 2025, there will be a billion elderly people aged over 60 in the world (Rosenblatt, 1997). Currently, there are 33.2 million elderly aged over 65 in the United States, comprising one-eighth of the nation's total population. The growth of the elderly population is anticipated to continue, and from 2010 to 2030, the increase will peak as the baby-boom generation joins the elderly group (U.S. Bureau of Census, 1996).

As the elderly population increases, their consumption of health care services becomes greater, presenting an emerging qualitative issue of wellness for the elderly (Grupp, 1981). The increased use of health care services by the geriatric population has made them a new focus group in the health care system, changing the previous scope for the elderly in a more realistic way. And new positions such as geriatric nurse specialist and geriatric nurse practitioner have emerged during the last decades, demonstrating that the increased health needs of the elderly clearly impact health education and health

promotion.

The necessity of health care professionals to assess the health function of their consumers has been stressed by experts (Quinn & Ryan, 1979). As a professional health care field, the public health care has regarded it as an essential component to identify health function of the elderly people for the provision of more efficient health care services. Health function assessment means identifying an achievable change which will improve health promotion. The changes may be alternation in a preventive activity, a treatment, a service, a policy, or an environmental hazard.

To find ways to accommodate more appropriate health care for the elderly, studies to assess the health function of the geriatric population have been increasingly performed during the last several decades.

However, considering the fast-emerging diverse health issues surrounding the elderly, those studies have been inactive compared to other branches of research.

Therefore, the purpose of this study is to (1) explore the health functions such as perceived health status, physical functioning, and psychosocial needs and (2) discover the relationships among the health functions.

## II. METHOD

### *Design*

This study offers a cross-sectional descriptive study of the health function of Korean immigrant elderly living in Washington State.

One hundred-two Korean immigrant elderly were selected using the non-probability convenience sampling method and interviewed via a structured questionnaire, from which their health function was identified. Study subjects were recruited from three Korean churches and two Korean senior centers within the Seattle and Tacoma area in Washington State of Northwest America. Those elderly who had severe physical illness, such as Alzheimer's disease, cancer, Parkinson's disease, heart failure were excluded from this study.

Three indicative domains were used to assess the health function of the Korean immigrant elderly; (1) the health status, (2) the physical functioning, and (3) the psychosocial functioning.

### *Instrument*

The health function of the elderly subjects was measured by interviews using a structured questionnaire that contained both close and open-ended questions.

Each subject was interviewed for about 2 hours.

The instrument consisted of four parts, with 38 items: (1) demographics, (2) perceived health status, (3) physical functioning, and (4) psychosocial functioning.

The demographic variables included gender, age group, living situation, educational level, length of residence since immigration, the number of health problem, and the number of current medicine.

Perceived health status. The perceived health status consists of the fourteen-item questionnaire, which was modified by the investigator from a questionnaire developed by the Health Status Questionnaire (HSQ: Interstudy Outcome Management System, 1991). Information about the subjects' perceived health status was elicited as to how they feel about their current health status, appetite, digestion, urinary function, bowel function, hearing, vision, sleep, breathing and dental status during the month prior to interview.

The perceived health status was surveyed on a four-point scale, which ranged from one (very poor) to four (very good).

The reliability of this instrument was 0.780 in Cronbach's alpha value.

Physical functioning. The physical functioning consists of the seven-item questionnaire which was developed for this

study, following the basic structure and rationale of the questionnaire developed for the Dupage, Illinois, County Health Department Survey (Managan et al., 1974).

The physical functioning indicated capacity during the month prior to interview in the activities of daily living adapted to the apartment setting: getting about in the apartment, doing own laundry, washing, bathing, dressing, putting on shoes, getting around outside apartment complex, and cutting toenails.

The physical functioning was surveyed on a four-point scale which ranged from one (inability to function at all) to four (no functional difficulty).

The reliability of this instrument was 0.732 in Cronbach's alpha value.

Psychosocial functioning. The psychosocial functioning consists of the ten-item questionnaire, which was modified by the investigator from a questionnaire developed by Kim (1977), whose study was conducted in order to measure psychosocial functioning of community-dwelling Korean elderly.

The psychosocial functioning indicated discussing coping, providing a sense of security, setting goals to reach, dealing with confusion, changing family routines, relieving isolation, relieving strain, changing self-concept, informing about community service, and obtaining legal assistance.

The psychosocial functioning was surveyed on a five-point scale that ranged from one (bad) to five (excellent).

The reliability of this instrument was 0.755 in Cronbach's alpha value.

### *Data Collection*

The investigator contacted with the pastor and the chief of center to explain the purpose of this study, and obtain their permission to survey elderly individuals with their churches and centers. The churches and centers provided a list of names and addresses of the elderly subjects. The pastor and the chief were asked to announce this study and introduce the researcher to those elderly people. Later, the researcher made phone calls to all elderly nominated by the pastor and the chief. And it was crucial to ask for permission to interview the participants, and set up the time schedule and place convenient to the subjects. At the beginning of the interview, the consent form was given, and subjects signed it prior to implementing the survey. During the interviews, the investigator spoke slowly so that the elderly subjects could comprehend the interview questions. The subjects were informed that they could decline to answer any point they chose.

After completing each interview, the investigator assigned an identification number to each participant to insure confidentiality.

The period of data collection was April 10<sup>th</sup> to September 20<sup>th</sup>, 2000.

*Data analysis*

Descriptive correlation statistics were used to deduce the study findings. As this was a survey study to measure the health function of the Korean immigrant elderly, the descriptive method was considered the most appropriate for analyzing study data acquired through structured interviews. The process of computed nominal data entry used for data

analysis. Anonymous raw data were entered into SPSS. Percentages, frequencies, central tendency, dispersion, and correlation coefficient were computed to determine characteristics for the entire sample.

III. RESULTS

*Demographic Characteristics*

Demographic information included in this study was gender, age, living situation, level of

<Table 1> Demographic Characteristics of the Respondents

| Variables                             | Category              | N                     | %     |
|---------------------------------------|-----------------------|-----------------------|-------|
| Gender                                | Male                  | 35                    | 34.3  |
|                                       | Female                | 67                    | 65.7  |
| Age                                   | 65-74 years           | 26                    | 25.5  |
|                                       | 75-84 years           | 62                    | 60.8  |
|                                       | 85 and over           | 14                    | 13.7  |
|                                       |                       | (Mean=77.97, SD=6.02) |       |
| Living situation                      | Living together       | 39                    | 38.2  |
|                                       | Living alone          | 63                    | 61.8  |
| Level of education                    | No formal/Ele. school | 59                    | 57.8  |
|                                       | Middle/High school    | 36                    | 35.3  |
|                                       | College               | 7                     | 6.9   |
| Length of residence since immigration | Less than 10 years    | 15                    | 14.7  |
|                                       | 10 to 20 years        | 56                    | 54.9  |
|                                       | More than 20 years    | 31                    | 30.4  |
|                                       |                       | (Mean=14.90 SD=6.54)  |       |
| Number(s) of perceived health problem | None                  | 7                     | 6.9   |
|                                       | 1 - 2                 | 77                    | 75.5  |
|                                       | 3 and over            | 18                    | 17.6  |
| Number(s) of medicine taking          | None                  | 5                     | 4.9   |
|                                       | 1 - 2                 | 76                    | 74.5  |
|                                       | 3 and over            | 21                    | 20.6  |
| Total                                 |                       | 102                   | 100.0 |

〈Table 2〉 Perceived Health Status of the Respondents (N=102)

| Items                                      | Mean | SD   |
|--|------|------|
| Current health status                      | 2.78 | 1.06 |
| Perceived health status compared to others | 2.95 | 1.11 |
| Appetite                                   | 3.15 | .89  |
| Digestion                                  | 3.00 | .84  |
| Controlling urinary function               | 2.87 | .88  |
| Controlling bowel function                 | 2.82 | 1.00 |
| Vision                                     | 2.65 | .80  |
| Joint/muscle pain                          | 2.26 | 1.09 |
| Breathing                                  | 3.02 | .81  |
| Dizziness                                  | 2.41 | .85  |
| Hearing                                    | 2.10 | .79  |
| Sleep                                      | 2.37 | .64  |
| Weight consistency                         | 2.53 | .71  |
| Dental status                              | 1.97 | 1.10 |
| Total                                      | 2.63 | .97  |

education, length of residence since immigration, the number of health problem, and the number of current medicine (Table 1).

The total number of participants was 102 Korean immigrant elderly, 65.7% of them was female.

The mean age of the total sample was 77.97 years (SD=6.02) with 25.5% aged 65 to 74, 60.8% aged 75 to 84, and 13.7% aged 85 and above. 61.8% of the participants lived alone, and 38.2% lived together with their family members. In terms of education, 57.8% of the subjects had no formal or an elementary school education, 35.3% had a middle or high school education and 6.9% had a college education.

The length of stay in the U.S. since

immigration was 14.90 years(SD=6.54) of mean value and reported as less than 10 years for 14.7%, as 10 to 20 years for 54.9% and more than 20 years for 30.4% respondents.

In general, most of the subjects reported being in good health. 6.9% of the subjects did not have any health problem; 75.5% of the subjects reported having one to two health problems. 4.9% participants did not take any medicine, and 74.5% of the subjects took one to two medicines.

#### *Perceived health status*

Fourteen items were used as indicators to measure the perceived health status of the Korean immigrant elderly. The score range of responses for each item was one to four, with one representing bad, to four, excellent.

<Table 3> Physical Functioning of the Respondents (N = 102)

| Items                    | Mean | SD  |
|--------------------------|------|-----|
| out the house            | 3.80 | .42 |
| Getting around the house | 3.72 | .53 |
| Doing housework          | 3.65 | .61 |
| Bathing self             | 3.80 | .42 |
| Dressing                 | 3.87 | .34 |
| Cutting toenails         | 3.83 | .40 |
| Using transportation     | 3.72 | .59 |
| Total                    | 3.77 | .47 |

The item that showed the highest health status was appetite, with a mean score of 3.15 (SD=.89), and the item that showed the lowest health status was dental status, with a mean score of 1.97 (SD=1.10) (Table 2).

*Physical Functioning*

Seven items were used as indicators to measure the physical functioning of the Korean immigrant elderly. The score range of responses for each item was one to four, with one representing inability to function at all, to four, no functional difficulty. The item

that showed the highest physical functioning was dressing, with a mean score of 3.87 (SD=.34), and the item that showed the lowest physical functioning was doing housework, with a mean score of 3.65 (SD=.61) (Table 3).

*Psychosocial Functioning*

Ten items were used as indicators to measure the psychosocial functioning of the Korean immigrant elderly. The score range of responses for each item was one to five, with one representing bad, to five, excellent.

< Table 4> Psychosocial Functioning of the Respondents (N = 102)

| Items                             | Mean | SD   |
|-----------------------------------|------|------|
| Discussing coping                 | 3.18 | 1.20 |
| Providing a sense of security     | 3.19 | 1.38 |
| Setting goals to reach            | 3.53 | 1.33 |
| Dealing with confusion            | 3.32 | 1.21 |
| Changing family routines          | 2.83 | 1.32 |
| Changing self-concept             | 3.28 | 1.04 |
| Relieving isolation               | 2.80 | 1.22 |
| Relieving strain                  | 3.74 | .86  |
| Informing about community service | 3.71 | .90  |
| Obtaining legal assistance        | 3.83 | .91  |
| Total                             | 3.30 | 1.14 |

<Table 5> Pearson Correlation Coefficients among Perceived Health Status, Physical Functioning and Psychosocial Functioning (N = 102)

| Variables                | Perceived health status | Physical functioning | Psychosocial functioning |
|--------------------------|-------------------------|----------------------|--------------------------|
| Perceived health status  | -                       |                      |                          |
| Physical functioning     | .471 (P=.000)           | -                    |                          |
| Psychosocial functioning | .402 (P=.000)           | .235 (P=.018)        | -                        |

The item that showed the highest psychosocial functioning was obtaining legal assistance, with a mean score of 3.83 (SD=.91), and the item that showed the lowest psychosocial functioning was relieving isolation, with a mean score of 2.80 (SD=1.22) (Table 4).

*Association among Perceived Health Status, Physical Functioning, and Psychosocial Functioning*

Health status perceived by the subjects was found to be statistically significant and positively correlated with physical functioning (r=.471, P=.000) and with psychosocial functioning (r=.402, P=.000) respectively. And physical functioning was also found to be statistically significant and positively correlated with psychosocial functioning (r=.235, P=.018) (Table 5).

These findings suggested that the subjects who had higher perceived more health status were more likely to be the good health function.

IV. DISCUSSION

Many researchers have identified functional status as the essential variable in determining an elder's health needs (Becker & Cohen 1984, Matteson 1997). Functional status represents an individual's overall level of functioning and can be depicted as the composition of various physical, psychosocial capabilities.

The purposes of this study were to explore the degree of the health function and discover the relationships between the perceived health status and the health function among the immigrated Korean elderly people in Washington State.

Generally, the Korean immigrant elderly showed high functional efficiency with little dependency on others. The mean score of their health function was 3.77 (physical functioning, scale of 1-4) and 3.30 (psychosocial functioning, scale of 1-5). The results were similar with a study done by German et al.

(1995), which found that the mean score of the health function of white American elderly were 3.78.

Other indicators used to measure the general health status of the sample were their perceived wellness in appetite, digestion, urinary and bowel function, hearing and vision, sleep, joint/muscle pain, breathing, dizziness, and weight consistency. But the necessity for more exploration of dental problems in Korean immigrant elderly was detected. To prevent severe dental loss, there should be an emphasis placed by health care providers on appropriate oral management. The Korean immigrant elderly had the most difficulty in doing housework among physical functioning indicators. Elderly living in Korea seemed to involve small in domestic work because most of the household chores were usually done by a daughters-in law. However, Korean immigrant elderly have do be their housework by themselves.

The subjects were socially isolated or at risk of isolation. Social networks seem to be weak and passive for Korean immigrant elderly. Benzeval et al. (1992), in their analysis of the Londoners subsection of the Health and Lifestyles Survey (HALS) data, concluded that social deprivation is associated with poor health. People from minority ethnic groups, particularly the elderly and those from the first generation, are more likely to be

isolated. Korean immigrant elderly may become isolated socially due to their language barrier. And they may have to some psychosocial conflict because of the different ways of interacting with others in the new society.

The findings of this study may be particularly useful to health care providers so that they can reduce health disparities and increase health-related behavior to promote the health for Korean immigrant elderly living in United States.

It is critical for health care providers to assess the old people's physical and psychosocial health functioning when working with Korean immigrant elderly people having of health problems.

## REFERENCES

- Becker, P. M., and Cohen, H. J. 1984. The functional approach to the care of the elderly: A conceptual framework. *Journal of the American Geriatric Society* 32:923-29.
- Benzeval, M. Judge, K. and Solomon, M. 1992. The health status of Londoners; A comparative perspective. King's Fund Institute, London.
- German, P. S. et al. 1995. Extended coverage for preventive services for the elderly: Response and results in a demonstration

- population. *American J. Public Health* 85:379-86.
- Grupp, C. A. 1981. A description of the health service needs of adult day care participants. Unpublished master's thesis, University of Washington, Seattle, WA.
- InterStudy Outcome Management System. 1991. *The health status questionnaire*. The InterStudy Quality Edge, 1.
- Kim, H. 1977. *Health needs of the elderly : community survey in Yonhee 1 dong*. Unpublished master's thesis. Yonsei University, Seoul, Korea.
- Managan, D., et al. 1974. Older adults: A community survey of health needs. *Nurs Res* 23:426-432, Sept.-Oct.
- Matteson, M. A. 1997. Functional assessment of the elderly. *Nurse Practitioner Forum*. 8(3):91-98.
- Quinn, J. L., and Ryan, N. E. 1979. Assessment of the older adult; A holistic approach. *Journal of Gerontological Nursing*, 5(2):13-18.
- Rosenblatt, D. E. 1997. Functional assessment. *Health Visitor* 69(8):261-64.
- U.S. Bureau of Census. 1996. Current population reports, special studies, 65+ in the United States (Publication No. p 23-190). Washington, DC: U.S. Government Printing Office.