Published in final edited form as:
*J Adv Nurs*. 2008 September ; 63(5): 517–526. doi:10.1111/j.1365-2648.2008.04746.x.

# Experiences and challenges of informal caregiving for Korean immigrants

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## Abstract

**Aim—**This paper is a report of a study designed to explore the caregiving experiences of Korean Americans.

**Background—**Increasing numbers of older people in the Asian population place important long-term care demands on Asian caregivers, yet minimal attention has been given to the issue of caregiving in this group. The current study attempts to fill the gap by describing Korean American caregivers' unique caregiving experiences from their perspectives.

**Method—**A qualitative research design using a focus group approach was employed to discuss caregiving experiences in a cultural context. Data were collected over an 8-month period in 2005. Twenty-four informants, mostly women, at varying points surrounding caregiving participated in a focus group interview. Each focus group lasted about 1 ½-2 hours. Thematic analysis was conducted by two bilingual researchers.

**Findings—**Three key themes were identified: the caregiver role – competing priorities and beliefs, the extent and impact of caregiving, and the need for education and culturally-tailored support systems. Ten subthemes were identified within the three major themes: (1) facing double challenges; (2) changing attitudes about filial piety (*Hyo*); (3) providing care; (4) feeling out of control; (5) going through changing family dynamics; (6) being connected vs. providing connection; (7) paying back; (8) learning by themselves; (9) recognizing differences and (10) reconsidering geriatric care systems.

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Author contributions
HRH & KK were responsible for the study conception and design. HRH & KK performed the data collection. HRH, YC & MK performed the data analysis. HRH & YC were responsible for the drafting of the manuscript. HRH made critical revisions to the paper for important intellectual content. HRH, MK & KK obtained funding. HRH, MK, JL & KK provided administrative, technical or material support. HRH supervised the study.

**Conclusion—**The caregiving experiences described by Korean American families point to the need to identify and develop more focused outreach programmes as well as more culturally appropriate support services for this rapidly increasing population.

### Keywords

caregivers; challenges; experiences; focus groups; immigrants; Korean American; nursing

## Introduction

The number of older people worldwide is rapidly increasing because of various factors including improvements in technology, medical care, and nutrition, as well as elevated fertility in many countries during the two decades after World War II (United Nations; UN Population Division. 2002). It is projected that the average lifespan will extend by another 10 years by 2050 (UN Population Division. 2002). The growing number of older people increases demands on caregiving related to chronic diseases and disabilities, which affect older adults disproportionately and creates major public health challenges.

## Background

The number of Asian Americans is expected to reach 34 million by 2050, when they will represent 9% of citizens in the United States of America (USA), as compared to 4·2% (11·9 million) in 2000 (Barnes & Bennett 2002). By 2050, people over 65 years of age are projected to be 13·4% of the total Asian population in the USA, which is seven times their current numbers (US Census Bureau 2000). Net immigration appears to be an integral part of the growth of the Asian population; the foreign-born Asian population in the USA grew from 9% in 1970 to 25% in 2000 (US Census Bureau 2002). This increasing number of older people increases informal (unpaid) caregiving demands in the Asian population (National Alliance for Caregiving and American Association of Retired People; NAC/AARP 2004).

An increasing numbers of studies have documented various aspects of informal caregiving. For example, African American caregivers have a more varied group of extended helpers (e.g. friends, church members) than White people, who often use only immediate family members (e.g. spouse) in their networks (Burton *et al.* 1995). This observation parallels the findings of Hart *et al.* (2007). Some ethnic groups have values about reciprocity, filial obligations and a sense of responsibility for providing care to older family members. Black and Hispanic caregivers are reported to have strongly held beliefs concerning filial responsibility (Clark & Huttlinger 1998, Sterritt & Pokorny 1998, Dilworth-Anderson *et al.* 2005). Strong filial obligation increases the frequency of emotional aid to parents for both Korean and Chinese Americans (Ishii-Kuntz 1997).

Although filial responsibility to fulfill caregiving roles is generally expected throughout much of the world, adherence to these beliefs appears to be weaker among White caregivers than has been reported among non-White caregivers (Ishii-Kuntz 1997, Dilworth-Anderson *et al.* 2005). The notion of filial piety, embedded within Confucianism, prevails in East Asian countries, such as China, Taiwan and Korea, where caregiving is seen as a natural extension of the commitment to the parents in exchange for the parents' care (Sung 2001, Lo & Russell 2007, Tang *et al.* 2007). In South Asia, caregiving responsibilities are framed by the concept of *karma*, which is associated with the Buddhist belief system (Limpanichkul & Magilvy 2004). The law of karma means that good acts will lead to good consequences and bad acts will lead to bad consequences. Several researchers have reported that taking care of parents and sick elders is viewed by South Asian caregivers as a good deed, which is an important tenet in their law of karma (Limpanichkul & Mcgilvy 2004, Sethabouppha & Kane 2005).

Receiving formal support is considered beneficial to caregivers as their caregiving role becomes more challenging (Cox 1999). Ethnic minority caregivers tend to underutilize formal services, however, because of cultural and language barriers (Levkoff *et al.*1999,Ho *et al.* 2000). Studies have documented a need for culturally-sensitive formal support services. For example, Cuban American caregivers have reported a need for more support services that include caregiving training, family support groups, case management and respite care (Mintzer *et al.* 1992). Likewise, Black caregivers have identified the need for information and referral services (Cox 1999).

Studies of immigrant caregivers in Canada (Neufeld *et al.* 2002, Stewart *et al.* 2006), Israel (Soskolne *et al.* 2006, 2007) and Australia (Lo & Russell 2007) indicate that immigrant caregivers share similar challenges, such as economic strain associated with settling in a new country. Migration can alter the structure of the social network of a caregiver in ways that affect the caregiver's access to support. For example, family members or friends who would normally provide support to the caregiver may live in a different country and may not be available (Soskolne *et al.* 2006, 2007). Support from institutional or community sources may also be limited by programmes that restrict immigrant caregivers' access or lack cultural sensitivity (Neufeld *et al.* 2002, Stewart *et al.* 2006).

Korean Americans (KAs) represented 10·3% of total Asian Americans in 2000, a 54% increase since 1990 (Barnes & Bennett 2002). Today's KAs are predominantly monolingual, first-generation immigrants who maintain cultural beliefs and attitudes since coming to the USA, for the most part when they are 20–40 years of age (Barringer *et al.* 1993). Despite their increasing numbers, the characteristics of KAs regarding caregiving practices and the impact of caregiving on caregivers' lives have rarely been studied, especially for those who speak little or no English. Also lacking is research that examines the impact of changing cultural values or acculturation processes on perceptions of caregiving and caregiving practice. A unique set of caregiving conflicts may arise in immigrant cultures when family members are at different levels of acculturation and have different values or beliefs related to caregiving. This study was designed to fill this knowledge gap by exploring KA caregiving experiences. Exploring the experiences of KA caregivers is a useful first step for guiding the planning, development and delivery of appropriate care for this population.

## The study

### Aim

The aim of this study was to explore the caregiving experiences of Korean Americans.

### Design

A qualitative approach was adopted and focus groups were conducted to describe the unique caregiving experiences of KA caregivers. This approach allows researchers to assess what participants describe as aspects of their culture that influence their caregiving in their own words and context. Information is obtained from sharing and comparing responses among a group of participants that have a central element of their experience in common (McLafferty 2004). This is a valuable approach in cross-cultural work, in that the interviewer is free to pursue topics in more depth and to gain better understanding of cultural values and group norms concerning a certain phenomenon as a result of shared knowledge (Hughes & Dumont 1993).

## Participants

We recruited a purposive sample of 24 informants. Inclusion criteria included: being over the age of 18 years, living with or providing informal care for at least 12 months for a KA relative or non-relative aged 60 years or older. Participants were all first-generation immigrants and mostly female (83%). The length of caregiving ranged from 1 to 20 years. The main illnesses or health problems experienced by care recipients included diabetes, stroke, dementia, hypertension, arthritis and frailty (see Table 1).

## Data collection

Eight focus groups were conducted in Korean over an 8-month period. The bilingual first author acted as moderator and a research assistant as note-taker. Using a topic guide, the moderator asked a series of open-ended questions about caregiving, following the general introductory statement: ‘I am interested in what it is like for you in your daily life to provide care to your parent and the things that might make your caregiving easy or hard’. Participants were encouraged to share their perspectives, provide data on topics they believed were most important, and inform the moderator about additional topics that might need attention but which otherwise would not have been identified. The names of participants were changed to ensure confidentiality. Efforts were made to ensure the interview environment was non-threatening and comfortable (e.g. refreshments were offered). Each focus group was held at a community location (e.g. senior centre, community centre), lasted about 1½–2 hours and was tape-recorded and transcribed verbatim for analysis.

## Ethical considerations

This study was approved by an institutional review board. Potential participants were recruited through announcements in newspapers, senior centres and word-of-mouth. Potential participants contacted the researcher after seeing the advertisement, at which time they were screened for study eligibility. Once their eligibility was confirmed, the researcher explained the study, assured them of confidentiality and obtained informed consent. Those who completed the interview received 60 U.S. dollars to compensate for their time and travelling expenses (1 US $ = 0·513 pounds sterling = 0·647 Euros).

## Data analysis

Two bilingual investigators independently completed the coding. Transcripts were subjected to content analysis using a framework of key concepts and themes derived from the data. The categories guiding coding had to meet specific criteria (i.e. inclusive and useful) (Morse & Field 1995). The coding process entailed the extraction of significant statements from transcripts and their classification into appropriate categories. Following the comprehensive coding process, a thematic analysis was conducted to classify common themes within the framework into larger categories (Krueger 1994). Analytic procedures such as generation of matrices helped us to identify linkages among the concepts. First, we analysed data for each participant and each focus group. We then compared data from caregivers in varied situations including gender, age and caregiving situations, to examine the possible influence of these variations. We compared the themes identified with field notes (Morse & Field 1995).

## Rigour

Interviews conducted in Korean were analysed in Korean and final results were translated into English by a professional translator. Bilingual investigators who had participated in the analytic process and have in-depth knowledge of Korean culture worked closely with the translator. Decisions and choices made, translation procedures followed and resources used were discussed by the research team. Trustworthiness of the analysis was addressed by a number of methods (Lincoln & Guba 1985). In addition to independent coding by two bilingual investigators, the first author met with other bilingual investigators regularly to discuss coding and to identify areas in which conflicting coding had occurred. Confirmability was supported by extensive note-taking during meetings to clarify the process of interpreting the data and to document the basis for the themes identified. Transferability was addressed by sharing findings with study consultants and by returning to the literature.

## Findings

Caregivers' stories provided the context for the views that they had of themselves, immigration and caregiving. To illustrate overarching issues, a thematic framework of key categories was developed based on three themes: the caregiver role – competing priorities and beliefs, the extent and impact of caregiving and the need for education and culturally tailored support systems. These main themes were able to characterize the caregiving experience through 10 subthemes (Table 2).

### The caregiver role – competing priorities and beliefs

**Facing double challenges—**Recalling the past or present included each caregiver's sense of what struggles they had encountered, between a much-wished success of settling in a new country and the strong (but changing) hold of the traditional value of filial piety, *Hyo*. For KA caregivers, it was not easy to care for parents within harsh immigrant life. Participants had worked extremely long hours to survive in the USA, many running small, family-owned businesses (e.g. liquor stores, grocery stores, dry cleaners). They struggled between surviving in the USA successfully and making constant efforts to take good care of their parents, as a culturally expected, desirable behaviour. One son described caregiving as ‘a burden’ because he had to earn money to live. He stated, ‘It does not mean I am unwilling to take care of my parents’.

Traditionally, the obligation for taking care of parents is the responsibility of the (eldest) son. However, the work of providing direct care is not enforced on the son but on his wife, the daughter-in-law. However, the rising labour force participation rates of women after immigration may interfere with their historical caregiving responsibilities. One daughter-in-law commented:

> I wake at 5 a.m. and go to work Monday through Saturday. I come home around 7 p.m. I prepare his [father-in-law] lunch and dinner before I leave for work…We thought [about] nursing home but this is a small community; everybody knows everybody. We don't want to be blamed for being bad children who don't take care of their parent, particularly me, being a bad daughter-in-law who comes into this family and then breaks the family harmony.

**Changing attitudes about filial piety—**A consensus among participants was that it would still be best if adult children took care of their parents. However, a process of transformation in regard to participants' beliefs about caregiving structure was noted. At one end of the filial piety continuum were conservatives who believed that children have to take care of their parents despite all other considerations. These people were mostly daughters. As one daughter described:

> I think it is inhumane not to take care of my old parents. They will not live so long. I don't know [about] American society very well, but even though it has good social welfare system and good facilities, these can't provide love.

At the other end of the filial piety continuum were more acculturated liberals. A non-relative caregiver in her 70s who had been in the USA for over 30 years stated:

> I think we need to see things differently now. Many Korean Americans think it is wrong to send parents to nursing home, but nursing home is actually better [than keeping elderly parents home alone] and provides better quality service…I don't want my children to take care of me. I want an independent life with dignity. I told my children not to dare dream of living with me. I don't want to be left alone in an empty house.

## Extent and impact of caregiving

### Providing care—
Participants discussed a wide range of caregiving activities they had provided, such as skin care for pressure ulcers and administering medications. They gladly accompanied sick elders to their doctors and collected dispensed prescriptions. Sometimes they sat with the elders and read or sang for them. Other caregiving activities included assistance with meal preparation, house cleaning, laundry, transportation and shopping. One daughter said:

> I helped [my dad's] exercise and physical therapy. Since he became unable to move by himself, I bought a wheelchair so I could move him around in his apartment. I massaged his hands, gave him medication, and so on…I did my best to take care of my dad.

One Korean tradition based on Confucianism pertains to the attitude towards the opposite sex. There is an old saying 'Do not sit together if you are older than 7′, which means that a man and a woman should not interact (even sitting together) freely once they reach a certain age. Some caregivers reported issues encountered when they tried to give care requiring physical contact with a care recipient of the opposite sex. The relationship between daughter-in-law and father-in-law needed to be especially courteous, as one daughter-in-law described:

> At first, when my father-in-law had a stroke, he tried to avoid me because he was shy about showing his body. So, I told him not to be shy because I was there to take care of him. I touched his excrement, held his body and wiped it out. Since then, he seemed to get mental stability and appreciated it.

### Feeling out of control—
Caring for sick elders was physically and psychologically demanding. As caregiving continued, caregivers often felt frustrated. One daughter said:

> She [my mother] asked me for water about 2–3 O'clock in the morning. She tried to do it by herself, not wanting to disturb my sleep. But she frequently makes mistakes, wetting her clothes. I had to clean up the mess that she made in the middle of the night.

Some said that they could not even get sick, since there would be no one else to take care of the sick elder. One husband stated:

> I used to travel a lot. But now, I have to take my wife to a hospital for dialysis every other day…I can't really think about me that much.

One son who took care of his father with dementia shared:

> He is so stubborn and easily enraged. Sometimes he goes to his room to put on his shoes [note. Koreans do not wear shoes inside home]. One day, I told to him to go to the other side of the house if he wanted to put on his shoes; he got angry. He always stands firmly by wrong things. I've been very stressed because of him, and I got hypertension.

#### Going through changing family dynamics—

Often, the gap between the expectation that the sick elder would get better and the reality of their unchanging condition caused feuds between family members. As time passed, taking care of the sick elder became the primary caregiver's responsibility. Caregivers thought that their hard work was not appreciated by other family members, who became harsh critics when caregivers expressed frustration and stress. One daughter said:

> Even neighbours and friends speak soothing words to me. But, my families get angry rather than soothe me. It's very tough. They say, 'Can't you endure even that little thing? All of us have undergone those things…' I can't get rid of the anger from these experiences. I keep thinking, 'How could they do this to me?'

#### Being connected vs. providing connection—

Caregiving became more than just providing care, particularly among non-relative volunteers. They talked about the feeling of 'being connected' as a result of caregiving. One non-relative caregiver stated:

> My patient doesn't want to eat alone; so I sit with her, eat with her, talk with her and go shopping with her. It's great to see her big smile, because I can feel that she appreciates what I do for her. I am 69 years old and retired. When you are old, you just don't have that kind of confidence that you used to have. Helping others helps me to keep this feeling that I am still connected to this world.

#### Paying back—

In this study, the burden of caring appeared to be better endured by spouses than adult children or daughters-in-law. Husbands appreciated their wives' devotion to them and their family members. When their wives became sick, they willingly accepted the role of caregiver to compensate for the wives' lifelong labour with their families. One husband whose wife had stroke said:

> She served my parents so well and sacrificed herself to raise our kids…In traditional Korean culture, a grown man does not express his affection in public. But, now I hold her [wife] hands while we exercise in the park.

### The need for education and culturally-tailored support systems

#### Learning by themselves—

Caregivers identified a lack of information about what to do or what not to do as one of the most important challenges they faced. They had to learn how to take care of the sick elders by themselves because resources were limited. One daughter said, 'I was like a nurse. I learned how to control the Ringer's solution, pull out the needle and care for bedsores. I consider myself lucky because my brother is a doctor'. A husband of a wife with diabetes who had received kidney dialysis explained how he tried to collect necessary information:

> My wife has been diabetic for 10 years. We didn't know anything about food control and 1 day she fainted because of low sugar. I asked people that I knew at the church what I should do. Each said different things.

A non-relative caregiver of a stroke elder stated:

> I was trying to bathe her but moving her from bed to bathroom was extremely hard because she was so heavy. I wasn't sure if I was supposed to lift her this way or that way. It would be nice if I knew how to take care of stroke patients, if there is anything that I need to be careful about.

#### Recognizing differences—

The participants of this study came in contact with mainstream healthcare systems in the course of caring for sick elders. They were divided into two groups: satisfied vs. dissatisfied with the elder care system. The former group was a minority; they said that the mainstream system (e.g. nursing home) was best as they could obtain various services, including emergency care when needed. One son noted:

> I love this American system. As soon as I came here, I thought this is paradise for the elderly. The people who stay there [nursing homes] feel comfortable regardless of who or when. I couldn't have survived without this help.

Most participants, however, were not satisfied. The main barriers to adequate and satisfactory service involved language and food. Participants were unable to communicate with mainstream care providers and so many had a fear of deciding to admit a family member to a nursing home. One non-relative caregiver stated:

> I used to drop by [a nursing home] 2–4 days a week to see this old lady with homemade Korean foods…They [nursing home staff] could speak only English but she could speak only Korean. They provided American foods only but she couldn't eat them. She had eaten Korean foods for almost 80 years!

Even when the language was not an issue, participants were ambivalent about the use of formal services; use of such services was seen as a last resort. They thought that USA care providers could not understand Korean caregivers, let alone sick Korean elders, even if they were able to speak English, because the USA culture is different from the Korean. One caregiver, who had been in the USA for 42 years and was fluent in English stated:

> I like the American system and know about it pretty well, but I think Koreans should be taken care of by Korean caregivers because they share common language and culture. Whether you like it or not, you lose your memory as you get older… especially those with limited memory tend to forget English and feel definitely comfortable being around Koreans.

**Reconsidering elder care systems—**Caregivers talked about being unable to find culturally-acceptable, adequate alternatives. Being exposed to Western culture, some discussed using nursing homes or home health aides if family members could not take care of the sick elder by themselves. However, they were not satisfied with these alternatives:

> …so they put their mother in a nursing home, which was OK because the son and his wife had been too busy to take care [of their mother]. But they had been too weary to come to the nursing home. He [the son] was a wealthy man, but he was not good to his mother…People would think this is ridiculous.

Another caregiver commented:

> Maybe you could send your parents to a nursing home, if you have to. But I would never send my parents there; it's inhumane. As a family, we can work this out. We should work this out.

Participants concluded that an answer would be having an elder care service tailored to Korean culture. In particular, they stressed that public interest should be expanded to reconsider today's elder care systems and to establish a mechanism to support immigrant elders with a different language and culture from mainstream society. They listed establishing Korean shelters or nursing homes and training Korean home health aides as potential strategies, and recommended calling for help from Korean volunteers. They commented that if these ideas were realized, they would have no worries about getting older. One daughter caregiver stated:

> If I tell [my parents] that there's a Korean nursing home, my parents would reconsider. They would think they'd better stay in such a place where they can

communicate in Korean and eat Korean food rather than stay in their busy son's or daughter's house alone most of the time.

## Discussion

Our findings suggest that the caregiving structure of today's Korean families with chronically ill or frail senior members continues to be largely dependent upon informal caregivers. The results are consistent with previous studies (Foley *et al.* 2002, NAC/AARP 2004) revealing that caregiving responsibilities fall heaviest on ethnic minorities. This may reflect the cultural value that the fulfillment of the caregiving role is considered a natural part of family obligation, as reported in non-White communities (Foley *et al.* 2002, Jones *et al.* 2002). KA caregivers were reluctant to allow older family members to go into nursing homes, and considered sending parents to a nursing home as 'inhumane'. This culture of stigma associated with nursing home placement appears to be particularly strong among recent immigrant groups (Jones *et al.* 2002, Scharlach *et al.* 2006). The KA caregiving structure, primarily relying on adult children, may also reflect the fact that adult children often act as brokers between this confined ethnic community and the wider mainstream society for their aged parents (Han *et al.* 2007).

Despite cultural norms regarding family obligations, changes in selection of caregiver and in family values were noticeable. A few participants weighed providing quality care (by sending family members to nursing home) against leaving sick or frail members home alone because of busy lifestyles as new immigrants. In addition, as traditional roles for KA women were challenged by working outside the home, and conflicts between traditional and role demands were inevitable. The simultaneous existence of filial piety and filial autonomy has been reported by a few recent studies of immigrant families (Pang *et al.* 2003, Mausbach *et al.* 2004, Scharlach *et al.* 2006).

Most family caregivers described feelings of being trapped as a consequence of caregiving. Because the relationship between KA family caregivers and care recipients may not be voluntary or reciprocal, but the consequence of a sense of duty, these caregivers may be at high risk of negative experiences and adverse consequences for their own well-being. Similar negative issues were highlighted previously (Lane *et al.* 2003, Pinquart & Sörenson 2003, NAC/AARP 2004). In comparison, non-relative caregivers focused on more positive aspects of caregiving, such as being connected or keeping them going. These positive experiences among non-relatives appear to be related to the nature of their voluntary caregiving. In addition, while caregiving activities assumed by family members often involve constant vigilance and care, services provided by non-relative volunteers may be occasional and include less demanding, need-based activities, such as friendly visiting, transportation, meal preparation, shopping or minor chores (Jellinek 2001, Lane *et al.* 2003). Variations in reciprocity in the caregiver's relationship with the care recipient may be another important factor which differentiates those with positive and negative caregiving experiences. Neufeld and Harrison (1998) found that caregivers who had positive relationship with care recipients valued caregiving as an opportunity to give importance to the contributions that the care recipient had made in the past. When reciprocity was absent, caregivers described caregiving on the basis of obligation with either mixed or negative feelings. Similar to the results of Neufeld and Harrison's (1998) study, KA caregivers who experienced positive relationships with the care recipient in the past, such as husbands whose wives had sacrificed themselves for the husbands' families, valued the service of their spouses in the past and were able to find meaning in their caregiving situations.

**What is already known about this topic**

- As societies get older the need for informal caregiving is rapidly increasing.
- Tasks performed by caregivers are physically, emotionally, socially and financially demanding.
- Although a wide range of supportive care services are available, caregivers in ethnic minority groups use more informal as opposed to formal support services than White caregivers.

**What this paper adds**

- Korean American families with chronically ill or frail senior members continue to depend on informal caregivers due, in part, to their strong cultural tradition of filial piety, *Hyo*.
- The interaction of filial piety, filial autonomy, and conflicts between them is noticeable in Korean American family caregiving.
- Korean American caregivers, as predominantly first-generation immigrants, are often left without systematic help because of language barriers, and differences in food and culture are additional barriers to utilizing formal support services.

We found that the majority of KA caregivers were left without systematic help because of language and cultural barriers as a predominantly first-generation immigrant group. Home and community-based services have grown in importance in the long-term care system over the past decade because of the large amount of health care spending on institutionalized care (Polivka & Zayac 2006). In our study, KA caregivers were uncomfortable about leaving parents in the care of strangers. Reluctance to accept formal support was primarily associated with concern that any formal caregivers would not have the necessary language skills and cultural sensitivity to make their services acceptable, as also reported by Bangladeshi caregivers in the United Kingdom (Merrell *et al.* 2005).

## Implications for nursing and health policy

The structure and values of KA caregivers remain relatively traditional and the majority of caregivers still prefer to care for ill elders at home. Nurses are the healthcare professionals who have the greatest opportunity for contact with caregivers, and play an important role in working with both care recipients and caregivers. Our findings imply that nurses need to acquire a more refined understanding of changing cultural norms (i.e. the simultaneous existence of filial piety and filial autonomy) and the life context of KA caregivers, and assist them in negotiating the potential conflicts between traditional values and the demands of caregiving. The findings also point to the need to identify and develop more culturally-appropriate support services for this rapidly-increasing population. More targeted outreach and information services are necessary to reach this group. Nurses could work with ethnic faith communities to recruit and train Korean-speaking volunteers to deliver short- and long-term respite services more palatable to KA caregivers. When designing nursing interventions, relationship status to the care recipient should be taken into account to help in ameliorating any negative impact of caregiving, particularly among daughters-in-law. At the system level, mainstream agencies could address linguistic and/or cultural barriers often experienced by immigrant caregivers by recruiting and training qualified interpreters or volunteers and offering on-going transcultural education for existing professionals. In addition, to enhance accessibility, information on community services available to immigrant caregivers could be offered in the language of caregivers to make it linguistically acceptable.

### Study limitations

While the suggested size of focus groups is 6–12 (Krueger 1994), scheduling problems prevented us from conducting a focus group with this number. As a result, some focus groups consisted of two participants. This might have affected the interaction between participants. The selection of participants from one metropolitan area in the USA limits representativeness. It is well-known that caregiving involves many time-consuming tasks. Such time constraints often make recruitment of caregivers challenging (Dilworth-Anderson & Williams 2004). A number of strategies have been suggested, including having an iterative conversation rather than a simple response to a query, allowing more flexible interview times (e.g. lunchtimes or evenings), or assigning the same interviewers to communicate with and interview study participants (Dilworth-Anderson & Williams 2004, Steinhauser *et al*. 2006). Finally, caregivers were interviewed together as a group, and this might have influenced the findings by limiting participants' willingness to reveal their beliefs and feelings in the presence of other caregivers. For example, some sensitive topics, such as sending parents to nursing home, might not have been fully discussed to avoid embarrassment.

## Conclusion

This study adds to the limited literature in caregiving research by exploring in-depth the experiences and beliefs of KA caregivers. As our society becomes more culturally-diverse, healthcare providers need to evaluate more critically the provision of culturally-appropriate care tailored to the needs of individuals and their families. Our findings indicate the need for greater attention in research and practice to the needs of this rapidly-growing population.

## Acknowledgments

This study was supported by a grant from the Agency for Healthcare Research and Quality (HS13779) and in part by the Centre for Collaborative Intervention Research at the Johns Hopkins University (P30 NR008995). Dr Choi was a postdoctoral fellow at the Johns Hopkins University School of Nursing at the time of the study.

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## Table 1

Characteristics of focus group participants

| Interview | Caregiver age | Caregiver gender | Relationship | Care recipient conditions |
|---|---|---|---|---|
| Group 1 | 72 | F | Non-relative | Dementia |
| | 69 | F | Non-relative | Dementia |
| | 70 | F | Non-relative | Diabetes, hypertension |
| | 63 | F | Non-relative | Stroke |
| Group 2 | 59 | F | Non-relative | Frailty |
| | 62 | F | Mother-in-law | Dementia |
| | 50 | F | Non-relative | Stroke |
| Group 3 | 54 | F | Mother | Frailty |
| | 45 | F | Father-in-law | Stroke |
| | 56 | F | Mother | Frailty |
| Group 4 | 44 | F | Parents | Diabetes (mother)<br>Stroke (father) |
| | 68 | F | Mother | Frailty |
| | 65 | F | Mother | Dementia, hypertension |
| Group 5 | 76 | F | Husband | Diabetes |
| | 58 | F | Non-relative | Stroke |
| | 56 | F | Mother | Diabetes |
| | 54 | F | Parents | Frailty |
| | 50 | F | Parents | Frailty |
| Group 6 | 80 | M | Wife | Diabetes, recent heart surgery |
| | 70 | M | Wife | Stroke |
| Group 7 | 67 | M | Wife | Diabetes |
| | 51 | F | Mother-in-law | Diabetes, arthritis |
| Group 8 | 47 | M | Parents | Dementia |
| | 40 | F | Mother-in-law | Frailty |

F, female; M, male.

## Table 2

Dominant themes and subthemes related to caregiving experiences among Korean American immigrants

| **Themes** | **Caregiver role – competing priorities and beliefs** | **Extent and impact of caregiving** | **Need for education and culturally tailored support systems** |
|---|---|---|---|
| Subthemes | Facing double challenges<br>Changing attitudes about filial piety (*Hyo*) | Providing care<br>Feeling out of control<br>Going through changing family dynamics<br>Being connected vs. providing connection<br>Paying back | Learning by themselves<br>Recognizing differences<br>Reconsidering geriatric care systems |