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Research Article

Effects of Health Status and Health Behaviors on Depression Among Married Female Immigrants in South Korea

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SUMMARY

Purpose: This study examined the effects of health status and health behaviors on depression in married female immigrants in South Korea.
Methods: Sampling 316 immigrant women from the Philippines, Vietnam, China, and other Asian countries, a cross-sectional research design was used with self-report questionnaires that assessed sociodemographic characteristics, health status, health behaviors, and depression.
Results: There were significant differences in stillbirth experience, induced abortion, morbidity, perceived health status, meal skipping, and physical activity between depressed and nondepressed immigrant women. After adjusting for sociodemographic variables, stillbirth experience, poorer perceived health status, more meal skipping, and less physical activity were associated with greater depressive symptoms.
Conclusions: Both health status and health behaviors had significant impacts on depression, suggesting that development of nursing interventions and educational programs should be targeted towards improving maternal health, healthy lifestyle, and subjective health perception to promote married female immigrants' psychological well-being.
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Introduction

Every year, a large number of women migrate as brides from developing countries to developed countries in East Asia including Japan, Singapore, Taiwan, and South Korea [1]. Koreans are well-known for maintaining a tradition of their racial ethnic homogeneity [2]. However, since the mid-1990s, the proportion of low-income Korean men who have passed the conventional marital age range and married foreign-born women from China, Vietnam, Mongolia, Thailand, the Philippines, and other developing countries has increased [3,4]. As a result, the number of married female immigrants has steadily grown. There are 235,947 married female immigrants in 2013, mostly from China, followed by Vietnam, and the Philippines [5,6].

Married immigrants may confront various culture clashes and incidents in their adaptation process because of different socio-cultural, economic, and political circumstances of the new country [3]. Particularly in Korea, married female immigrants report taking 4 months of preparation, on average, before migration, which is an inadequate amount of time to acquire knowledge about Korean society and be familiar with its culture [7]. Moreover, 83.7% of married female immigrants become pregnant within a year of arrival in the country and 77.5% of immigrants with less than 3 years of residency experience childbirth [8]. Also, 41.2% of married immigrant women live with parents-in-law, relatives, and step-children [9]. Consequently, married women who take on the responsibilities of wife and daughter-in-law with the additional burden of childrearing often face greater difficulties adjusting to Korean society, and these could pose a risk for emotional distress or depression [10]. The occurrence and levels of depression among

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married female immigrants are higher compared to their Korean-born counterparts [11,12].

Recently a variety of studies have been developed to investigate the prevalence of depression and factors that influence depression among married female immigrants in Korea. Whereas considerable research has shown the effects of demographic (immigrants' country of origin, economic hardship, and time since immigration), sociocultural (Korean language proficiency and acculturative stress), and psychosocial factors (self-esteem, social support, marital adjustment, and life satisfaction) on depression [1,13–15], little is known as to whether health-related factors such as health status and health behaviors are associated with depression. Health status, including self-rated health status is one of the major predictors of depression [12,16–19]. Unhealthy behaviors such as smoking [20], excessive alcohol use [21], physical inactivity [22–24], and unhealthy diet [25–27] are widely recognized as important determinants of depression.

Health problems related to pregnancy and childbirth are more frequently reported in married immigrant women than in native Korean women. Immigrant women tend to marry and achieve pregnancy at a relatively young age while adjusting to the new culture. Along with lack of language proficiency and sources of information and care, these can be contributing factors that cause a high-risk pregnancy [28].

Female immigrants who came to Korea to marry have different health problems and health-behavior patterns from those women who were born and raised in Korea [29–31]. Health problems in these immigrant women are also dissimilar to those of immigrant women in different countries, such that immigrants in Korea manage more reproductive health issues at early stages after arrival [9,31,32]. Although systematic evaluations of physical functioning, mental health, and health behaviors have been a part of research on immigrant health in other countries [33], only recently have inquiries regarding health status and related outcomes among married female immigrants occurred in Korea [8,34]. In this article, we examine health status and health behaviors, and their effects on depression among married female immigrants in Korea.

Methods

Study design

A cross-sectional survey was used to examine the health status and health behavior-related factors that may affect depressive symptoms among 316 married female immigrants in South Korea.

Setting and samples

To participate in this study, immigrant women had to be married to a Korean man and had been living in the country for less than 10 years. Study participants' countries of origin included the Philippines, China, Japan, Vietnam, Mongolia, Thailand, and other Asian countries. Married female immigrants living in Korea for more than 10 years were not included because immigrants largely maintain the same health status as before during the first 5 years after immigration. However, immigrants appear to be assimilated to the health of the local population within approximately 10 years [35]. Married immigrants from the United States and developed European countries were also excluded from the study based on previous research, in that their health-related characteristics, including disease rates and subjective health, are distinct from those found in married immigrants who were from developing countries [36].

Participants were recruited using convenience sampling from public health centers, social welfare services, multicultural-family support programs, and community healthy-family support centers in four urban areas and four rural areas. Of the 466 women who were initially enrolled, 77 did not complete as few as one item of the questionnaire that measured depressive symptoms, 21 made unclear responses to some items, and 52 stopped completing the questionnaire, citing fatigue and difficulties in understanding the questions. This resulted in a sample of 316 female marriage immigrants reported in the study.

Ethical considerations

The survey was conducted with participants who provided signed informed consent on a form approved by the Institutional Review Board of the Ewha Womans University, Seoul, Korea (IRB no.: IRB 2009-1-2). The form described the purpose of the study and gave assurance of self-determination, privacy, and anonymity.

Measurements

The survey consisted of four domains assessing study participants' sociodemographic characteristics, health status, health behaviors, and levels of depression.

Sociodemographic characteristics

Participant background characteristics included country of origin, age, education, area of residence (urban/rural), time since immigration, and poverty level. Because of difficulties IN obtaining information on income, participants were asked whether they have been living below the national poverty line. The poverty line is defined by the criteria for food security used in the Korean Nutritional Health and Nutrition Examination Survey Report [37]. Participants were classified as living below the poverty line if they agreed to the statements, “Sometimes food was scarce because of insufficient income,” and “Often food was scarce because of insufficient income,” and living above the poverty line if they agreed to the statements,“I could get enough and diverse food whenever I want,” and “I could get enough but not diverse food whenever I want”.

Depression

The 20-item Center for Epidemiologic Studies Depression Scale (CES-D; [38]) translated into Korean [39] was used to appraise depressive symptomatology on a 4- point scale (0 = *rarely or none of the time,* to 3 = *most or all of the time*). A cut-off point of 16 was applied to determine whether participants are at risk for clinical depression. Cronbach's alpha for the Korean version CES-D was .85 in this study.

Health status

We assessed participant health status based on Body Mass Index (BMI), which was computed by dividing weight by height in meters squared (kg/m^2). According to previous studies, immigrants in the Western industrialized countries are a vulnerable group in terms of health [40,41]. The changes in diet, nutritional status [42–44] and physical activities [45,46] have a negative effect on health status. In particular, one out of three female immigrants who came to Korea to marry was underweight, and the disease with the highest prevalence among this group was found to be anemia [31,47]. Given the negative effects of having a BMI higher or lower than the normal range [48], it is meaningful to study the BMI of female immigrants. Following the recommendations of the World Health Organization Regional Office for the Western Pacific, the International Association for the Study of Obesity, and the International Obesity Task Force on Obesity for classification of obesity in Asians [49], a BMI of 18.5–25.0 kg/m^2 was categorized as normal to

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