Socio-demographic and Psychological Correlates of Posttraumatic Growth among Korean Americans with a History of Traumatic Life Experiences

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ABSTRACT

This study examined socio-demographic and psychological correlates of posttraumatic growth (PTG) among Korean Americans (KAs) with traumatic life experiences. A total of 286 KAs were included. Being a woman or having a lower annual household income had positive associations with PTG, while having no religion had a negative association with it. In addition, praying and visiting a mental health professional for coping with stress or for psychological problems was positively associated with PTG. Higher resilience scores increased PTG, while depressive symptoms decreased it. We suggest reinforcing help seeking behaviors and accessibility to care facilities, and gender specific strengthening programs for enhancing PTG among KAs.

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INTRODUCTION

Trauma refers to how individuals emotionally react to terrible events, such as the sudden loss of a loved one, natural disasters (e.g., earthquakes, floods, or hurricanes), serious accidents (e.g., car crashes), physical or sexual assault (e.g., being battered or raped), domestic violence, wars, or political violence (American Psychological Association, 2015). Immigration has also been considered a traumatic stressor because it involves separation, loss, change, conflict, and demands that could pose a psychological threat to an individual (Berger & Weiss, 2002; Calhoun & Tedeschi, 1999). Many immigrants struggle with stressful experiences due to culture loss, culture shock, readjustment, racial/ethnic discrimination, and/or prejudice (Berger & Weiss, 2002). Whether man-made or natural, trauma can be a threat to a person's quality of life, as well as to their physical and psychological wellbeing. In the United States (US), trauma is the leading cause of death for those ages 1–46 and trauma injury accounts for 30% of all years of life lost (National Trauma Institute, 2015).

Traumatic experiences, including immigration, have been reported to create psychological problems, such as posttraumatic stress disorder (PTSD), depression, or anxiety, that warrant treatment when individuals fail to cope successfully (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; North et al., 1999; Zoellner, & Maercker, 2006). PTSD is

a common psychological outcome after trauma, as an incident can still present a person with trauma long after it is over. The trauma survivor can re-experience the traumatic event as intrusive memories, flashbacks, nightmares, overwhelming emotional states, or physiological reactivity (Giller, 1999; Zoellner, & Maercker, 2006). Depression is also common among those who develop PTSD after trauma. A study of Oklahoma City bombing survivors reported that 23% had depression after the bombing, compared to 13% before it (North et al., 1999). A national survey showed that the prevalence of depression is up to 5 times higher in people with PTSD than in those without (Kessler et al., 1995).

Although negative psychological outcomes have been mainly studied in trauma research, the literature has also reported that traumatized persons can resolve their trauma, strengthen their coping skills regarding potential traumatic stressors and/or conflicts, and develop positive psychological attributes, such as posttraumatic growth (PTG) and resilience (Bonanno, 2005; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004). PTG refers to positive psychological changes that occur as a result of struggling with trauma or any extremely stressful event (Tedeschi & Calhoun, 2004). These positive changes can manifest in one or more of 5 domains: positive changes in relationships, a sense of new possibilities for one's life, a sense of increased personal strength, a change in spiritual views, and an increased appreciation of life (Tedeschi & Calhoun, 1996). Resilience is defined as personal characteristics that enhance an individual's social and psychosocial adaptation or competence in the face of overwhelming adversity (Wagnild & Young, 1993). The concept of resilience implies that individuals have internal resources to identify

stressful events, appraise their capacity for action, confront the events with a sense of competence, and deal with the events effectively (Caplan, 1990).

Although both PTG and resilience are salutogenic attributes, their relationship has been debated. Levine, Laufer, Stein, Hamama-Raz, and Solomon (2009) reported an inverse relationship between PTG and resilience among those exposed to terror and wartime trauma. On the contrary, Bensimon (2012) found that resilience was positively related to PTG among those with various levels of trauma.

Empirical studies on the association between PTG and depression reveal an inconclusive picture. Many cross-sectional studies have found no relationship between PTG and depressive symptoms (Cordova, Cunningham, Carlson, & Andrykowsky, 2001; Joseph, Williams, & Yule, 1993), while other studies have reported that PTG and depression are significantly negatively correlated (Frazier, Conlon, & Glaser, 2001). No study found a positive relationship between PTG and depression.

In order to cope with trauma or an emotional reaction to it, trauma survivors often employ self-protective coping strategies, including hypervigilance, dissociation, avoidance, or numbing, which may be temporarily effective, but are not the best ways to resolve their overwhelming emotions (Giller, 1999). Researchers have suggested different forms of coping as more effective adaptations to traumatic events: acceptance, positive appraisal, religious or spiritual coping, problem-coping, and emotion-focused coping, such as emotional social support (Linley & Joseph, 2004). Particularly, the use of prayer has been examined as a type of religious or spiritual coping strategy. A recent study reported a positive correlation between prayer and PTG among trauma survivors (Harris, Erbes, Engdahl, et al., 2010).

With regard to the relationship between PTG and socio-demographic characteristics, PTG research has reported socio-demographic differences. In a literature review of 39 studies, Linley and Joseph (2004) found that females had higher PTG than males and that younger people showed higher PTG than did their older counterparts. Some studies have suggested that higher PTG is related to higher levels of income and education (Cordova et al., 2001; Updegraff, Taylor, Kemeny, & Wyatt, 2002) but the findings are not conclusive.

Although researchers have examined the significant effects of PTG after traumatic events, as well as the relationship between PTG and potential predictors in the general population, few studies have focused on ethnic minority populations, including Korean Americans (KAs). KAs are the fifth-largest Asian group in the US (Hoeffel, Rastogi, Kim, & Shahid, 2012) and nearly 80% of KAs ages 18 years and older were born outside of it (Pew Research Center, 2012). Research has reported that KAs are exposed to highly stressful and traumatic life events, such as ethnic discrimination (Lee, 2005), acculturative stress (Oh, Koeske, & Sales, 2002; Park & Bernstein, 2008), intergenerational conflicts (Kim & Cain, 2008), and domestic violence (Chic, Patel, & Poore, 2011). Prior literature has also documented that KAs are at higher risk of mental health difficulties, including depression and anxiety, compared to US community samples (Kim, Han, Shin, Kim, & Lee, 2005; Oh et al., 2002; Park & Bernstein, 2008).

Identifying socio-demographic and psychological factors for PTG after traumatic experiences will contribute to understanding mental health outcomes among KAs and developing culturally competent mental health services for this population. The present study aimed to investigate the levels of PTG among KAs with a history of traumatic life experiences by possible predictors (e.g., socio-demographic characteristics, types of coping strategies, depressive symptoms, and resilience), and the relationships between PTG and these predictors in this population.

METHODS

Research design, sampling, and procedures

A purposive and non-probability sampling strategy was used. Sampling eligibility criteria included: 1) KAs age 21 and older, residing in New York City (NYC) or in metropolitan New Jersey; 2) able to speak, read, and write Korean language fluently; and 3) having experienced at least one traumatic life event. The participants were allowed to indicate their traumatic life events and transitional period since the first traumatic event in their own words. As the questions were open-ended, the scope of the traumatic life events was broad, from general traumatic events to immigration-related ones. They included loss of a loved one, divorce/separation, domestic violence, physical/mental/sexual abuse, acute/chronic disease, financial problems, sudden accidents, acculturation related stress, etc. Study participants were mainly recruited at two health fairs organized by local hospitals in Queens, New York City, and in Teaneck, New Jersey, and from Korean community organizations (e.g., Korean senior centers, Korean Protestant and Catholic churches, Buddhist temples), as well as from Korean beauty salons and other retail stores. The study purposes and procedures were explained in Korean prior to conducting the survey and all participants gave written informed consent. During the survey, trained interviewers were available to assist anyone who might need any assistance. All participants were provided $5 as compensation for their time.

Institutional Review Board approval was received from Hunter College, the City University of New York. Data were collected between July 2014 and November 2014. A total of 346 KAs participated in the survey. Of those, 286 completed at least 95% of the survey packet and were included in the data analysis.

Measures

Socio-demographic characteristics

Socio-demographic questions included age, gender, education (i.e., high school graduate or less, some college or above), annual household income (i.e., $19,999 or less, $20,000–$49,999, $50,000 or more), employment (i.e., full time/part time, unemployed/student/retired), marital status (i.e., married/cohabitating, single/widowed/divorced/separated), living arrangement (i.e., living alone or living with others), religion (i.e., yes or no), length of US stay, time since trauma, and coping strategies (i.e., pray, exercise, visit mental health professional, tai chi/yoga/meditation/alternative medicine/others).

We also assessed self-assessed English language proficiency, as previous studies have shown it to be associated with acculturation, stress, mental health, and health care use among Asian immigrants (Kang et al., 2010; US Department of Health and Human Services, 2001). Proficiency was measured by three self-assessed items of fluency: speaking, reading, and writing. Responses were on a 4 point scale: 'excellent,' 'good,' 'fair,' and 'poor.' We divided the responses of each item into two categories: 'excellent' or 'good' = 'fluency' and 'fair' or 'poor' = 'no fluency.' Finally, subjects were grouped into three categories according to the total number of fluencies: 'not fluent in any,' 'fluent in one or two,' and 'fluent in all three items of speaking, reading, and writing.'

Posttraumatic growth inventory (PTGI)

PTG was measured by the PTGI (Tedeschi & Calhoun, 1996). The PTGI has 21 items with five subscales: Appreciation of Life (3 items), New Possibilities (5 items), Personal Strength (4 items), Spiritual Change (2 items), and Relating to Others (7 items). Each item has a 6-point Likert scale, ranging from 0 (Not at all) to 5 (Very great degree). For the total score and each subscale, higher scores indicate greater perceived growth or positive change. The PTGI has demonstrated high internal consistency ($\alpha = 0.90$– 0.96) and acceptable test-retest reliability ($r = 0.71$) in the US general population (Osei-Bonsu, Weaver, Eisen, & Vander Wal, 2012; Tedeschi & Calhoun, 1996). In addition, the concurrent, discriminant, and construct validity of the scale have been examined in diverse populations, including Korean populations (Linley, Andrews, & Joseph, 2007; Song, Lee, Park, & Kim, 2009; Tedeschi & Calhoun, 1996). The alpha coefficient was 0.960 in this sample.