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ORIGINAL PAPER

Resilience and Depressive Symptoms among Korean Americans with History of Traumatic Life Experience

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Abstract This study investigates socio-demographic characteristics and resilience and depressive symptoms among Korean Americans (KAs) with traumatic life experiences. Community-residing 285 KAs living in New York City and Teaneck, New Jersey completed questionnaires measuring traumatic life experiences, depressive symptoms, and resilience. Descriptive statistics, Pearson's correlations, and two-step hierarchical multiple regression analyses were conducted. 54% of KAs with traumatic life experiences reported at least mild depressive symptoms; greater resilience was associated with fewer such symptoms. English proficiency, length of time in US, marital status, and employment were significant predictors for depressive symptoms in the first step of multiple regression, but when resilience was introduced in the second step, it was the only significant predictor of depressive symptoms. The findings suggest that resilience should be supported to promote positive mental health outcomes for traumatized KAs who are depressed, and that resilience-focused interventions for this population should be designed.

Keywords Depression · Resilience · Trauma · Korean Americans

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Introduction

Substantial numbers of people worldwide experience traumatic events during their lifetimes. Prevalence has been estimated at 89.7% in the US (Kilpatrick et al. 2013), 73.8% in South Africa (Atwoli et al. 2013), 54% in Spain, 56.1% in Italy (Carmassi et al. 2014), 60% in Japan (Kawakami et al. 2014), and 60.6% in Northern Ireland (Ferry et al. 2014). Some of these people may be at increased risk for developing psychopathology, most commonly posttraumatic stress disorder (PTSD), major depressive disorder, and complicated grief (CG). Yet studies also report that only 5–10% of such individuals develop chronic psychopathology and that others overcome such events with little life disruption (Bonanno 2004).

According to Bonanno (2004), the four most common prototypical outcome trajectories and frequencies of adjustment following a traumatic event are resilience (35–65%), recovery (15–25%), delayed gradual return to normal levels of functioning (0–15%), and chronic distress (5–30%). Some of this variance can be attributed to the type, severity, and duration of the traumatic event; exposed individuals may reach higher levels of psychopathology when the exposure is more prolonged or severe (Bonanno et al. 2010). For example, a study with 2752 New Yorkers who were interviewed in the months following the 9/11 terrorist attacks indicated that chronic PTSD prevalence was estimated at 6% for those not physically injured and at 26% for those who were (Bonanno et al. 2006). Similarly, analysis of the National Vietnam Veterans Readjustment data, a sample of 1200 veterans, estimated chronic PTSD at 9% but at 28% among veterans with the highest levels of combat exposure (Dohrenwend et al. 2006).

Resilience is a personality characteristic or coping resource which facilitates overcoming adversity,

surviving stress, and rising above disadvantage (Wagnild and Young 1993). Resilient individuals have coping skills that allow them to effectively manage stressful situations, thereby either transforming those situations into less stressful ones or enabling them to come to terms with aspects of life that are uncontrollable (Wagnild and Young 1993). Most studies on resilience following traumatic events have focused on PTSD and found that persons with high resilience may have a lower risk of developing PTSD and psychopathology (Agaibi and Wilson 2005; Alim et al. 2008), and that resilience can also mediate to reduce depression and anxiety in otherwise healthy individuals (Hjemdal et al. 2011; Burton et al. 2009; Davidson et al. 2005).

While immigration is generally not considered to be a traumatic life event, Berger and Weiss (2003) claim that it can be considered a potential traumatic stressor because it involves separation, loss, change, conflict and demands that can severely challenge or shatter individuals' ways of making meaning and defining themselves. In addition to this more generalized immigration-related stress, Asians living in the US, whether or not they are immigrants, have historically experienced stress due to prejudice, racism, and discrimination (Sue and Sue 2003); for those who are immigrants, migration-related stress can accumulate over time during the acculturation period (Banks et al. 2006). When these stresses build without appropriate resolution and an insufficient support system, as it often is for immigrants who have left their families in the country of origin, they can be traumatic to the individual and/or to the family (Berger and Weiss 2003).

Korean Americans (KAs) are one of the fastest growing ethnic minorities in the US (US Census Bureau 2000) and 78% of adult KAs were born outside of the US (Pew Research Center 2012). Similarly, to other ethnic minority groups, KAs experience significant stressors as they encounter differences between the culture of origin and the dominant culture: learning a new language, interacting with different financial and occupational systems, changing roles for themselves and their family members, and experiencing new social norms (Park and Bernstein 2008). Studies with KA immigrants emphasize these challenges of immigration, such as acculturative stress, discrimination, lack of social support, insufficient financial resources, and limited language proficiency, often lead to psychological problems (Bernstein et al. 2011; Portes and Rumbaut 2006). These socio-cultural issues among KAs may lead to unexpected traumatic and highly stressful life events, such as domestic violence (Chic et al. 2011), high rates of divorce (Cohen 2014), intergenerational conflict with children (Kim and Cain 2008), and substance abuse (Takeuchi et al. 2007). In fact, studies suggest that KAs are at risk for emotional difficulties, including depression and anxiety (Kim et al. 2005) and early life traumatic stresses were associated with increased risk of developing depression (Seok et al. 2012).

Bernstein and colleagues (2011) found the prevalence of depression (13.2%) among KA immigrants to be almost that of the general U.S. population, a finding consistent with that of other studies, which report higher scores of depressive symptoms among KAs compared to U.S. community samples (Oh et al. 2002) and other racial and ethnic groups (Jang et al. 2005). While these problems are significant, such studies, as well as the larger media, emphasize the vulnerability and problems of KA immigrants, and implicitly convey a message that migration itself causes problems that cannot be overcome. However, this viewpoint neglects immigrants' sources of strength, survival strategies and opportunities for change and empowerment (van der Ham et al. 2014); not all KA immigrants develop these problems and/or disorders. Understanding the characteristics of KA immigrants who adapt and thrive can help mental health professionals to develop more effective interventions for those who do not.

In order to understand KAs' traumatic life stressors and its overall impact on their lives, it is important to understand how KAs perceive their experience of traumatic events. Although the Diagnostic and Statistical Manual (DSM)-5 defines a traumatic stressor as involving exposure to one's actual or threatened death, serious injury, or sexual violence, and listed related psychological symptoms (American Psychiatric Association 2013), recent studies on trauma, particularly from a researcher-clinician point of view, have widened the definition of trauma and one's traumatic experience. Tedeschi and Calhoun (2004) suggest that an event can be a traumatic stressor if it poses a threat to one's cognitive integrity–that is, if it represents a severe challenge to an individual's ways of understanding the world and his or her place in it. The individual's experience of the challenging events or circumstances help to determine whether it is a traumatic event or not; a particular event may be experienced as traumatic for one individual and not for another. In other words, how the individual labels, assigns meaning to, and is disrupted physically and psychologically by the challenging event will contribute to whether or not it is experienced as traumatic (SAMHSA 2014). In this study, the researchers explored KAs self-reported trauma which was based on the assumption that an individual is the best resource to identify whether one's own life experience was traumatic enough to disrupt his or her physical and psychological wellbeing.

The purposes of this study were:1) to investigate the relationship between resilience and depressive symptoms among KAs with self-reported experience of traumatic life events, and 2) to explore the association between KAs' sociodemographic characteristics and depressive symptoms. We believed that KAs with self-reported traumatic

life experience who report lower resilience would report more depressive symptoms. Findings may provide a basis for understanding the prevalence of KAs with traumatic life events that are depressed and may support the role of resilience in promoting positive mental health outcomes.

Methods

Sampling and Setting

Institutional Review Board approval was received from the City University of New York and all participants gave written informed consent. Eligibility criteria included: KA, irrespective of legal status, where they were born, or how long they had been in the United States; age 21 years or older; self-reported ability to speak, read, and write Korean language fluently; and reporting experiencing at least one traumatic life event. Potential participants were asked if they had experienced a traumatic life event. If they answered "Yes" and met other criteria, they were asked whether they wanted to participate in the survey. Three hundred and forty-six persons met the inclusion criteria and agreed to participate; 285 participants completed at least 95% of the data and were included in the analysis. Participants were recruited mainly during two health fairs organized by local hospitals in Queens, New York City, and in Teaneck, New Jersey, and also from Korean community organizations, including Korean beauty salons and other retail stores.

Data Collection

The instrument packet, which was only available in Korean, was designed to be completed in approximately 20–30 min. Trained interviewers, fluent in Korean, were available for those who needed assistance. All participants were given $5 as a token of appreciation for their time. Data were collected between July and November 2014.

Instruments

Socio-Demographic Characteristics

Socio-demographic questions included age, gender, length of time in the U.S., educational attainment, marital status, employment, annual household income, living arrangement (i.e., living alone or living with others), religion, and self-assessed English language proficiency.

Types of Traumatic Life Experiences

Participants were asked, "Have you ever been emotionally, physically or psychologically traumatized in life?" If they answered "yes", they were asked to describe the nature of the trauma. The traumatic experiences described by the participants were grouped with the common themes as following; Death of a Loved One, Acute/Chronic Disease, Financial Problems, Sudden Accidents, Divorce/Separation, Family Conflicts, Physical/Mental/Sexual Abuse, Domestic Violence, Acculturation Related Stress/Culture Shock, and Unspecified/Other (e.g., Natural Disaster). The types of traumatic life experiences reported by participants are presented in Table 1.

Depressive Symptoms

The Center for Epidemiological Studies Depression (CES-D) is one of the most widely used self-report instruments for depression screening in the general population (Kazarian 2009; Radloff 1977). The CES-D consists of 20 items, rated on a 4-point scale from 0 to 3. Total scores range from 0 (no depressive symptoms) to 60 (most severe depression); higher scores indicate more depressive symptoms. A score of 16 or higher has been used extensively as the cutoff point for significant depressive symptoms on this scale (Radloff 1977). The Korean version of the CES-D (CES-D-K) was validated with 594 college students and 228 community residing adults in Korea, and a Cronbach's alpha of 0.91 was computed (Chon et al. 2001); the alpha coefficient in this sample was 0.92.

Resilience

Wagnild and Young (1993) developed the Resilience Scale (RS), drawing from five concepts: perseverance, equanimity, meaningfulness, self-reliance, and existential aloneness. The RS has 25 items with a 7-point Likert scale, ranging from 1 (disagree) to 7 (agree); total scores range from 25 to 175, with higher scores indicating higher levels of resilience (Wagnild and Young 1993). The RS has been used with various age and ethnic groups and in a variety of settings (Humphrey 2003; Wagnild 2003), and has demonstrated good validity and reliability ($\alpha = 0.85$–0.94), as well as construct validity (Chon et al. 2001; Wagnild and Young 1993). The RS has been translated into Korean, validated with 459 Korean college students, and was reliable ($\alpha = 0.88$) (Kim and Lee 2011); the alpha coefficient was 0.95 in this sample.

Table 1 Descriptive statistics ($N = 285$)

	Frequency (%)	Mean ± SD (range)
Age (in years)		54.4 ± 16.6 (19–93)
Length of time in the U.S.		19.7 ± 11.1 (0.1–59)
Gender		
Male	116 (40.7)	
Female	169 (59.3)	
Marital status		
Married/cohabitated	163 (57.6)	
Single/other	120 (42.4)	
Education attainment		
≤High school	111 (39.4)	
≥Some college	171 (60.6)	
Employment		
Yes (full + part)	161 (56.9)	
No	122 (43.1)	
Annual household income		
<$10,000	34 (12.5)	
$10,000–$19,999	43 (15.9)	
$20,000–$29,999	47 (17.3)	
$30,000–$39,999	32 (11.8)	
$40,000–$49,999	25 (9.2)	
$50,000+	90 (33.2)	
Living arrangement		
Living alone	48 (16.8)	
Living with others	237 (83.2)	
Religion		
Yes	255 (89.8)	
No	29 (10.2)	
English proficiency		
Poor	168 (59.1)	
Fair	82 (28.9)	
Well	34 (12.0)	
Lifetime traumatic experiences		
Death of a loved one	87 (27.5)	
Acute/chronic disease	41 (13.0)	
Unspecified/other (e.g., natural disaster)	40 (12.7)	
Financial problems	38 (12.0)	
Sudden accidents	35 (11.1)	
Divorce/separation	28 (8.9)	
Family conflicts	24 (7.6)	
Physical/mental/sexual abuse	10 (3.2)	
Domestic violence	7 (2.2)	
Acculturation related stress/culture shock	6 (1.9)	
Resilience		114.9 ± 26.3 (31–169)
Depressive symptoms		17.4 ± 10.3 (0–53)
Yes (≥16)	154 (54.0)	
No (<16)	131 (46.0)	

Data Analysis

Descriptive statistics were used to describe socio-demographic characteristics, traumatic experiences, and mental health status (i.e., depressive symptoms and resilience). Pearson's correlation analysis was performed to test relationships among all variables. Two-step hierarchical multiple regression analyses were conducted to investigate whether socio-demographic characteristics and/or resilience were associated with depressive symptoms; the total score of depressive symptoms served as a dependent variable, and socio-demographic characteristics and resilience were used as independent variables. All the predictors were mean centered before they were entered into the multiple regression analyses. A p-value of 0.05 or less was considered as statistically significant. SPSS 21.0 was utilized for all statistical analyses.

Results

Table 1 displays descriptive information about the socio-demographic characteristics, types of traumatic life experiences, depressive symptoms, and resilience for this sample. The average participant was female, 54 years old, married or cohabited, lived with someone, had some college education, employed, had an annual household income of less than $40,000, identified with a religion, and had lived in the US for 20 years with a poor level of English language proficiency. The most common type of traumatic life experience was the death of a loved one and the least common was acculturation-related stress/culture shock. The mean score of resilience was 114. 9 ($SD = 26.3$). The mean score for depressive symptoms was 17.4 ($SD = 10.3$); 54.0% experienced at least mild to moderate depressive symptoms.

Table 2 shows Pearson's correlations. Depression was statistically inversely correlated with resilience and the strength of correlation between depression and resilience was medium ($r = -0.523$, $p < .01$). All of the socio-demographic characteristics, with the exception of marital status, living alone, and English proficiency, showed statistically significant correlations with depression and the strength of these correlations were moderately weak (range of $r = 0.123$–0.257).

Table 3 summarizes a two-step hierarchical multiple regression analysis for depressive symptoms. Socio-demographic characteristics were entered into the first step of the regression and four characteristics were found to be significant predictors of depressive symptoms: English proficiency, length of time in the U.S., marital status, and employment. Among socio-demographic variables, length of time in the U.S. was a relatively strong predictor of depressive symptoms ($\beta = 0.25$), followed by English

Table 2 Bivariate Correlations ($N = 285$)

	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	–											
2. Length of time in the U.S.	0.602**	–										
3. Gender	−0.003	−0.023	–									
4. Marital status	0.157**	0.065	−0.192**	–								
5. Education	−0.329**	−0.179*	−0.083	0.087	–							
6. Employment	−0.463**	−0.256**	−0.087	0.053	0.211**	–						
7. Income	−0.386**	−0.150*	−0.121*	0.170**	0.332**	0.378**	–					
8. Living alone	0.158**	0.167*	−0.066	−0.489**	−0.099	−0.091	−0.145*	–				
9. Religion	0.094	0.142**	0.101	−0.055	0.013	−0.105	−0.099	0.059	–			
10. English proficiency	−0.490**	0.010	0.013	−0.166**	0.420**	0.167**	0.324**	−0.058	0.014	–		
11. Resilience	−0.306**	−0.283**	−0.036	0.094	0.271**	0.328**	0.284**	−0.165**	0.276**	−0.138*	–	
12. Depressive symptoms	0.225**	0.209**	0.123*	−0.097	−0.214**	−0.230**	−.257**	0.021	−0.210**	0.097	−0.523**	–

*$p < .05$, **$p < .01$

Table 3 Multiple Regression analyses predicting depressive symptoms ($N=285$)

	Step1			Step2		
	B (SE)	*β*	T	*B* (SE)	*B*	T
Intercept	17.49 (0.59)	–	29.79***	17.43 (0.53)	–	32.63***
Age	−0.06 (0.06)	−0.10	−0.98	−0.03 (0.06)	−0.05	−0.60
Length of time in the U.S.	0.23 (0.08)	0.25	3.08**	0.13 (0.07)	0.14	1.90
Gender	1.49 (1.24)	0.07	1.20	1.53 (1.13)	0.07	1.36
Marital status	−3.33 (1.54)	−0.16	−2.17*	−2.51 (1.40)	−0.12	−1.79
Employment	−2.82 (1.39)	−0.14	−2.04*	−0.81 (1.29)	−0.04	−0.62
Education	−1.59 (1.41)	−0.08	−1.13	−0.39 (1.29)	−0.02	−0.30
Income	−0.45 (0.39)	−0.08	−1.18	−0.33 (0.35)	−0.06	−0.93
Living alone	−2.81 (1.96)	−0.10	−1.43	−3.29 (1.78)	−0.12	−1.84
Religion	2.04 (1.15)	0.06	1.03	0.58 (1.81)	0.02	0.32
English proficiency	−3.15 (1.15)	−0.22	−2.74**	−1.41 (1.08)	−0.10	−1.31
Resilience	N/A	N/A	N/A	−0.18 (0.02)	−0.45	−7.32***
R^2		0.18			0.33	
F value		5.67***			11.10***	
ΔR^2			0.15			
F for ΔR^2			53.64***			

Notes All predictors are mean centered

N/A not applicable

*p < .05, **p < .01, ***p < .001

proficiency ($\beta=-0.22$), marital status ($\beta=-0.16$) and employment ($\beta=-0.14$). In the second step of regression, resilience was the only variable that showed a statistically significant association with depressive symptoms. A one unit increase in resilience was associated with a 0.18 unit decrease in depressive symptoms, controlling for all socio-demographic characteristics. The final model yielded a good model fit with a $R^2=0.33$, accounting for a moderate proportion of the variance of depression. The second step of regression significantly improved the first model.

Discussion

This study was conducted with a convenience sample of community-living Korean speaking adults who reported a traumatic life event to identify the relationship between depressive symptoms and socio-demographic factors and resilience. We found that more than half (54%) of these KAs were living with significant depressive symptoms. Compared to the much lower (13%) prevalence of depression among KAs found by Bernstein and colleagues (2011), our finding is very high which may be due to the participants' history of at least one traumatic life experience. Similarly, Wingo and colleagues (2010) also found 52% prevalence of depressive symptoms among a low-income, highly-traumatized, predominantly African-American population.

The socio-demographic predictors associated with depressive symptoms found in the first regression model were English proficiency, length of time in the U.S., marital status, and employment status. While Won et al. (2017) also found marital status to be associated with depression, we did not find a relationship between depressive symptoms and gender, age, education level or annual household income in our sample as they found in the Korean sample. Being married, employed, and having better English proficiency were associated with less depression, while longer length of time living in the US was associated with more depression. Kim et al. (2015) assessed acculturation in an older Canadian and U.S. Korean immigrant population through two proxy variables—years of residence in the host country and English language proficiency—and found that these factors were significantly associated with depressive symptoms in the U.S. sample but not in the Canadian one. No relationship was found with marital status and, since their population was older, employment status was not measured in their sample. In comparison, being employed was initially associated with less depression in our sample, mirroring the well-recognized relationship between economic improvement associated with employment and reduction of negative psychological effects (Dagher et al. 2015).

We were interested in the relationship between resilience and depressive symptoms in a KA sample who reported traumatic life events. The second and final regression model showed that 33% of depressive symptoms were explained

by a combination of socio-demographic characteristics and resilience, but that resilience remained as the only statistically significant variable related to depressive symptoms. The mean resilience score (114.9) for our sample was lower than the mean found by Wagnild and Young (1993) (147.91) but similar to that found by Kim and Lee (2011) among Koreans college students (120.24) and Korean adult children of alcoholic parents (115.74). For comparison, the mean resilience score in a Japanese sample was 111.19 (SD = 19.47) (Nishi et al. 2010), 136.63 in a Spanish sample (SD = 19.56) (Las Hayas et al. 2014), and 130.23 in a Nigerian sample (SD = 17.08) (Abiola and Udofia 2011). Although our sample had a history of traumatic life events, their resilience scores were similar to those of other Asian populations. Lower resilience scores may be due to Eastern cultural tendencies to suppress expression of positive affect or personal strength (Seok et al. 2012). Furthermore, Asians tend to choose items along the midpoint on items involving positive emotions, which may explain the lower resilience scores compared to their non-Asian counterparts (Min et al. 2013).

Complex social and cognitive protective factors such as social support, social skills, prioritizing and planning behaviors, and goal efficacy are determinants of resilience (Ponce-Garcia et al. 2016). While participants were asked about socio-demographic factors such as gender or marital status, the presence or absence of these factors were not as significant as resilience in explaining depressive symptoms in this community-living sample of KAs. This study has some limitations, including a non-probability sample from one highly diverse urban region and self-reports. Despite these limitations, we were able to demonstrate that resilience has a significant, inverse correlation with depression and is an important factor in mitigating depressive symptoms; greater resilience is associated with fewer depressive symptoms in KAs who have experienced at least one traumatic life event. This finding is in agreement with similar research on resilience and depression with African American (Wingo et al. 2010), Japanese (Nishi et al. 2010), Spanish (Heilemann et al. 2003), and Chinese (Lim et al. 2015) populations. In addition, higher levels of resilience buffer the negative impacts of the onset of a new chronic illness on functional status and development of disability (Manning et al. 2016).

Research suggests that resilience, or certain aspects of resilience, is a modifiable construct (Leppin et al. 2014). Their systematic review and meta-analysis found that interventions used different conceptualization for the training program and so they broadly classified these programs based on whether they (1) sought to mitigate generalized or trauma-induced stress, (2) focused on developing resilience as an end goal or as a mediating variable, (3) were designed to be used in single/specific or multiple/general populations, and (4) were intended to be administered universally or in a targeted fashion (i.e. only "as needed"). Their overall conclusion was that participation in resilience training programs has a mild to moderate effect on improving mental health outcomes. A specific population resilience program could incorporate addressing discrimination, which Bernstein and colleagues (2011) found to be a significant predictor for depression, by encouraging ethnic identity pride, which Lee (2005) also found to be a protective-reactive factor against the effects of discrimination on depressive symptoms among KA college students.

Conclusion

This study was conducted with community living KAs who reported traumatic life events to identify socio-demographic factors associated with depressive symptoms and explore whether resilience acted as a buffer for those symptoms in order to provide foundational data for interventions promoting resilience in this ethnic minority population. As depression is a major public health issue, strategies to foster resilience may be cost-effective to address mild to moderate depressive symptoms. Clinicians providing services for KAs should be aware of the potential for depression and create referral processes tailored to address the mental health needs of this population. Creative strategies for utilizing technology for resilience training programs, such as on-line support groups facilitated in the language of choice, could be considered. Although socio-demographic factors were initially significant in this sample, resilience acted as a mitigating factor against depressive symptoms. More than half of this sample is living with significant depressive symptoms; providers need to be vigilant to screen for depression and assess resilience and tailored interventions should be available for this ethnic minority population.

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Compliance with Ethical Standards

Conflict of interest There is no conflict of interest regarding this manuscript.

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