Targeting and Tailoring:
Contextually Sensitive Approaches to Health Promotion, focusing on Korean Immigrants in the U.S.

Seunghye Hong
University of Hawai‘i at Mānoa
Myron B. Thompson School of Social Work

Rebecca L. Stotzer
University of Hawai‘i at Mānoa
Myron B. Thompson School of Social Work

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Abstract

Immigrant populations are heterogeneous across many dimensions in diverse contexts (e.g., social, cultural, historical, and developmental contexts). In designing health promotion interventions for immigrant populations, therefore, diverse contexts should be included to address diverse needs. There has been, however, little theoretical and empirical research on health promotion interventions for immigrants. Immigrant groups are an important focus for studies of contextualized health promotion efforts, not because immigrant groups are exceptionally unhealthy, but because the rising numbers and sheer diversity of these groups highlight the challenges inherent in contextualizing health promotion interventions in general. First, this paper presents a theoretical foundation for health promotion interventions for immigrant populations using a general model from the social sciences. Specifically, Thoits' (1995) stress process model will be applied to this paper, because her model is the best articulation of the key elements in classical stress and health theory: individuals' place in the social structure (including ethnic identity), stressors, and coping resources and strategies. Furthermore, contextual dimensions will be added to the examination of the stress process model for health interventions. Second, this paper scrutinizes how a general stress process model can be applied to immigration contexts to understand the mechanisms through which immigrants' stressors, coping resources, and coping strategies influence health outcomes. Third, the paper proposes directions for expanding effective health promotion strategies for immigrant populations in contextually sensitive ways, focusing on Korean immigrants' experiences. Such health promotion intervention should address theoretical features uniquely critical for immigrant populations as well as the broader determinants of immigrants' health. (252 words)

Introduction

The United States has a long history of regulating immigration. Historically, two big surges in immigration followed two major regulations. First, the National Origins Act of 1924 sought overall limits on immigration, and this legislation strongly favored immigrants from parts of Europe and Canada over other regions of the world. Second, the Immigration Act of 1965 replaced the former National Origins System, allowing an annual immigration quota of 20,000 individuals from each country. As a result, in the past 40 years, changes in immigration has led to a shift in the racial and ethnic composition of the U.S. While early immigration was primarily among those of European descent, recent immigration since the 1965 legislation is primarily from Asian and Latin American countries.

Immigrant populations encounter multiple barriers to maintaining good health. On arrival in the U.S., immigrants tend to be healthier than the population at large with respect to chronic diseases and disabilities. During settlement, numerous disadvantages may affect immigrants' health – stress, underemployment, downward mobility, discrimination, poor housing, lack of access to services, and inadequate social support, among others (Simich, Beiser, Stewart, & Mwakarimba, 2005). Many immigrants face social isolation, especially in the beginning, and are usually without the social supports they were accustomed to in their homeland. For example, one of the most important health challenges for new immigrants is simply learning "where" and "how" to get help – navigating the system when support is needed.

Cultural diversity in the U.S. can be directly attributed in large part to patterns of immigration. Given widespread recognition of the importance of cultural differences in recent years, the U.S. health system has responded by promoting culturally competent practices. Based on the objectives in Healthy People 2020, local health departments have increased the proportion of resources they allocate to establish culturally competent and linguistically appropriate community health promotion and disease prevention programs. This shift implies a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within the larger social context.

In summary, U.S. immigrants are important foci for studies addressing contextualized health promotion interventions. This is not because immigrant groups are exceptionally unhealthy, but because of the rising numbers and sheer diversity of these groups. A focus on

immigrants can clearly highlight the challenges inherent in contextualizing health promotion. As a result, such interventions can become more effective in attaining the promise envisioned for culturally competent public health practice.

The first purpose of this paper is to present a theoretical framework based on a general social science stress process model for health promotion interventions for immigrant populations. Specifically, this paper will employ Thoits' (1995) stress process model, because it articulates the key elements in classical stress and health theory: external influences, stressors, coping resources and strategies. Furthermore, this model sheds light on the importance of the individual's place in the social structure in understanding stress and coping process. Since immigrants' social place often changes after immigration (e.g. upward or downward social status), this emphasis is valuable.

The second purpose of this paper is to identify the best directions for future contextually sensitive health promotion strategies for immigrant populations; in particular, this paper focuses on Korean immigrants as an application of these theories and best directions. Since current literature on this topic is predominantly atheoretical and mono-cultural in focus, this paper examines how Thoits' general process model can be applied to immigrant populations as a useful foundational guide for improving health promotion planning for immigrants.

Stress and health:
Conceptual elements in Thoits' (1995) social science stress process model

Thoits' social science stress process model suggests that the pathway to well-being is a process that includes three components: 1) individual risk factors (e.g., gender), 2) individual stressors (e.g., life events and chronic strains) and 3) personal coping resources and strategies. This section will examine each of these key concepts.

Individuals' locations in the social structure

Individuals are exposed to different stressors, such as financial strain and discrimination, based on their locations in the social structure. The stress literature shows that socially disadvantaged individuals are especially vulnerable or emotionally reactive to stressors (Pearlin, 1999, p. 376; Thoits, 1995). A main premise of Thoits' stress process model is that coping

resources are distributed according to individuals' social status. For example, racial and ethnic minority groups, females, unmarried persons, and people with low socioeconomic status may demonstrate a lower sense of control and self-esteem as the consequences of poor coping resources. An important question for future research is whether or not these coping resources are also distributed differently by immigration status (i.e., refugee or immigrant, voluntary or involuntary).

Stressors: events and strain

Stressors are defined as "conditions of threat, demands, or structural constraints that, by their very occurrence or existence, call into question the operating integrity of the organism" (Wheaton, 1999, p. 177). Life events, chronic strain, and daily hassles are three major forms of stressors. Life events are "acute changes which require major behavioral readjustments within a relatively short period of time" (Thoits, 1995, p. 54), such as divorce, birth of a first child, or loss of a loved one. In contrast, chronic strain consists of "persistent or recurrent demands which require readjustments over prolonged mini-events which require small behavioral readjustments during the course of a day" (Thoits, 1995, p.54). Chronic strains are insidious as people face them during their everyday lives, and at the same time, their onsets are imperceptible (Matheson et al., 2006). Literature consistently shows that they are also damaging to both physical and mental health. Oddly, however, while life events have dominated the stress and health literature, chronic strain is far less studied and understood.

Coping resources and coping strategies

Coping resources are defined by Thoits as "social and personal characteristics upon which people may draw when dealing with stressors" (1995, p.59). Citing a definition of resources by Gore (1985), Thoits confirms that "resources reflect a latent dimension of coping, because they define a potential for action, but not action itself" (Gore, 1985, p. 266). Personal sense of control, mastery, and self-esteem are main examples of resources. Many studies show that personal resources (i.e., a sense of control and mastery) directly reduce both psychological distress and physical illness and have moderating effects on the link between stress and health (Kessler, Turner, & House, 1988; Mirowsky & Catherine, 1989; Thoits, 1995). One study on the effects of self-esteem shows that higher self-esteem reduced psychological distress and produced significant buffering effects on psychological symptoms (Turner & Roszell, 1994). The effects of

self-esteem on physical health remains undiscovered. Although Thoits' model used social support as a coping resource, the model deals almost exclusively with personal-level coping resources. Focusing mainly on personal-level as opposed to or in addition to community- or structural-level coping resources is a limitation of both Thoits' 1995 presentation and others' conceptualizations of the whole stress-processing model.

Reminiscent of the latent dimensional features of coping resources, Thoits' model also explores coping strategies to show the way people respond to stressors. Thoits defined coping strategies as "behavioral and/or cognitive attempts to manage specific situational demands which are appraised as taxing or exceeding one's ability to adapt" (1995, p.60). There are two kinds of coping strategies identified in the literature: problem-focused and emotion-focused strategies (See the work of Folkman & Lazarus, 1980). Researchers have assumed associations between coping resources and coping strategies. For example, many researchers assume that people with high self-esteem are more likely to use active, problem-focused coping strategies, while those with low self-esteem are more likely to use passive, emotion-focused coping strategies. Coping strategies are couched within coping styles, which are more general coping behaviors or habitual preferences for approaching stressors across various circumstances. Coping styles include withdrawing or approaching, denying or confronting, and becoming active or remaining passive.

Research shows that whether or not coping works effectively depends on the nature of the stressful circumstance that the individual faces, and whether they are appraised as controllable or uncontrollable. Appraisals of controllability are linked to either problem-focused coping or emotion-focused coping. When stressful situations and demands are appraised as controllable, people are more likely to use problem-focused coping strategies. When stressors are appraised as uncontrollable, people are more likely to use emotion-focused coping strategies. In general, problem-focused coping is considered to be more beneficial than emotion-focused coping.

Thoits (1995) asserted that the effectiveness of coping strategies or coping styles depends on the nature (e.g., chronic vs. acute, controllable vs. uncontrollable) and the form (e.g., divorce, illness, loss of job, or death of a loved one) of the stressor. For example, Mattlin and colleagues (1990) emphasize that coping efforts for chronic difficulties are more likely to be effective in reducing mental disorders (i.e., anxiety and depression) than for acute life events. Since community- or environmental-level stressors are more chronic and uncontrollable in nature, it is

thus valuable to add contextual features to the general stress process model.

Researchers speculate that unequal distribution of personal coping resources influences the use of effective coping strategies and consequently, how individuals respond to stressors (Pearlin, 1999). Thus, differential vulnerability to stressors is often attributed to a person's lack of coping resources, especially for those in a lower social status. Is the lack of individual-level coping resources the only reason for differential vulnerability to stressors? Or can it be attributed to lack of concomitant contextual-level coping resources for dealing with broader ecological concerns and stressors? An additional focus is needed to expand the limited individual-level only stress and coping process model to include a broader array of ecologically embedded stress and coping influences on human well-being. Coping research to date has tended to come primarily from the field of psychology, which traditionally has focused closely on individuals and far less on contexts. In contrast, public health and other health promotion fields have focused on key demographic (e.g., gender and ethnicity) and structural factors (e.g., neighborhood socioeconomic disadvantages and social disorganization) and far less on individual diversity within a seemingly homogeneous population group. It is critical for coping research to incorporate both individual and contextual factors.

In summary, Thoits' (1995) stress process model may be useful to (1) provide a framework to identify critical features of stressors, coping resources, coping strategies among immigrant populations, (2) to understand the mechanisms through which these general features influence immigrants' physical and mental health, and (3) to propose directions for expanding effective health promotion strategies for immigrant populations that take into fuller account features of the broader contextual environment such as characteristics of neighborhoods where immigrants live and/or work, including crowding, community violence, poverty, ethnic density, and housing issues.

Beyond Thoits: Contextually sensitive additions to the model

In the most recent line of study, researchers have begun to expand on Thoits' overall model to examine and incorporate physical settings and contexts, such as neighborhoods, into stress and health literature. The following review outlines some features of this newer on-going examination.

Stressful experiences are interpreted within a person-environment transactional

framework where transactions depend on the existence and impact of external stressors. That is, individuals are embedded in diverse contexts, such as residential community, that influence individuals' appraisal of the external stressors, which, in turn, mediate the impact of external stressors on individuals' health outcomes. Pearlin (1991) argues that the meaning of a stressor can depend on the surrounding context. Community stressors (e.g., neighborhood disadvantages, social disorganization, noise, crowding, violence, or crime) tend to be chronic external stressors. In residential contexts, community stressors are ongoing as a part of daily living. hese are difficult to avoid and are typically perceived as uncontrollable. Ecological chronic stressors are different from role-related stressors since they originate at a level above the individual and his or her interaction with role partners and peers. This form of stress can include reduced or lack of access to opportunity and structural reduction in available coping resources.

Recent research on persistent material deprivation, socioeconomic disadvantage, and neighborhood disorder points to the chronic stressors' negative impact on health. In the social science literature, local residential contexts (e.g., neighborhoods) are often identified as sources of chronic stressors, which, in turn, may lead to deterioration of individuals' health outcomes. Crowding, density, housing, violence, and crime are examples of contextual features that have been examined as environmental-level chronic stressors. They have been found to be associated with individuals' health and well-being. Furthermore, the strains created by the chronic nature of these environmental or ecological-level stressors not only have an impact on individuals' health, but can diminish residents' capacity to resist the pathological effects of all types of stressors.

Latkin and Curry (2003) examined the impact of neighborhood stress on depression using a prospective multilevel approach. They found that neighborhood perceptions of social disorder were positively associated with depressive symptoms and argue that social disorganization is an important chronic stressor among inner-city populations. They emphasize that depression should not be viewed only as an individual-level phenomenon, but that ecological factors are important for identifying and understanding neighborhoods in creating risk for depression among their residents. This line of thinking about chronic stress from ecological-level contextual sources has rarely been tested in the context of improving the well-being of immigrant groups.

Stress and health among immigrants

A major assumption of this paper is that health scientists have not yet thoroughly examined the associations between stress and health among immigrant populations either theoretically or empirically. Thus, existing efforts to design interventions to be culturally relevant remain somewhat shallow – that is, focused only on improving access to traditionally structured treatment services or offering traditional services in languages other than English. Truly preventive services would go much farther if they had an integrated focus on the conceptual issues discussed above. The next section outlines ways in which the general concepts in this review might be applied to immigrant groups and individuals. This investigation may provide valuable additions to the current literature, as a substantial body of research has established a strong and consistently positive relationship between stress and both mental and physical health; however, the applicability of these studies to immigrant populations is not clear.

Immigrants' locations in the social structure

Immigrants' locations in the social structure may or may not change in the new country following the immigration process. If changes to immigrants' locations in the social structure happen, we would conceptualize these phenomena in two dimensions: (1) immigrants' subjective changes in perception of their social locations, and (2) objective changes in immigrants' locations in the social structure. Immigrants' objective social position caused by employment status and financial earnings may be similar to their social position in the country of origin (e.g., similar level of personal income). Immigrants' perceptions of their position in the social structure, however, may differ from what they had in their country of origin (e.g., subjective downward social mobility).

For example, researchers have found that Korean immigrants as well as immigrants from other ethnic groups are highly educated and held professional and administrative positions before immigration to the United States (Kuo, 1984; Portes & Rumbaut, 2006). Since arriving in the U.S., however, they have not held jobs with comparable status, such as administrative positions; their perceived socioeconomic status might be lower than it was in their countries of origin. Despite their high level of education, they may be underrepresented in the top occupational categories (e.g., professional and managerial positions) and over-represented in the bottom categories (e.g., laborers). Dry cleaning shops, small grocery stores, and convenience stores are examples of significantly less desirable work settings experienced by educated immigrants

accustomed to professional status in their countries of origin (Kuo & Tsai, 1986; Portes & Rumbaut, 2006). Kuo (1984) found that Korean immigrants' lower socioeconomic and employment levels were related to their mental health, proposing that Korean immigrants are more likely to take lower prestige jobs compared to other Asians Americans with comparable education attainment. Language barriers appeared to be a particularly challenging task for Korean immigrants. Changed immigrants' social locations, either in an objective sense or subjective/perceived sense, may expose them to additional stressors, such as undesirable employment conditions and downward social mobility which may be quite different from those they experienced in their countries of origin.

Stressors related to immigration per se

Immigrant populations experience two kinds of stressors: (1) stressors directly related to immigration and (2) stressors that many non-immigrant Americans also experience. For example, leaving one's established community, social networks and support, acculturative stress, cultural conflicts, and difficulties in learning new languages are unique challenges for immigrants. Other stressors immigrants face are not necessarily unique to immigrants. For example, many non-immigrant Americans experience chronic stressors related to changes in employment, family relations, and other contextual factors, such as disadvantaged neighborhood contexts.

Existing literature shows that negative life events produce significant increases in emotional problems only when the events themselves generate persistent or recurrent strain. As for immigrants' experiences, the life event of immigration itself is neither positive nor negative. Immigration per se is not necessarily negative, and the immigration process as a whole can be perceived as a positive experience. However, the actual immigration process is a major stressful life event unique to immigrants. In comparison to the general population, immigrants' experiences while adjusting to the new country may result in many changes to everyday life producing multiple, sometimes unique, health-deteriorating chronic strains for which the immigrant has no prior preparation. When immigration generates strain (e.g., cultural conflict, economic strain, status inconsistency, job dissatisfaction, and downward social mobility), it increases the possibility of emotional problems leading to mental disorders or may produce an onset of psychological symptoms. For example, the characteristics of self-employed or unpaid

work held by Korean immigrants often leads to dissatisfaction. Since Korean immigrants are most likely to be self-employed because of having difficulty finding white-collar and professional occupations in U.S (Min, 1993), management of labor costs by hiring unpaid family members is necessary. As a consequence, Korean immigrants are reported to work as either self-employed workers or unpaid family workers. Related to high rate of self-employment, another consideration is that most of the employed Korean immigrant wives are full-time workers, working for eight or more hours per day, with many of them even working every Saturday and on Sundays (Hurh, 1998), which may generate strain, and increase the risk of physical or mental health problems.

As immigrants reside longer in the new country, they may experience types of stressors different from those impacting them at the beginning of their stay, such as emerging generational conflicts in the family, being a racial/ethnic minority, and discrimination (e.g., glass ceiling). Immigrants' experiences of being in a minority group and discrimination may be useful as an example. For Korean immigrants, different features of perceiving discrimination as a social determinant of mental health do exist based on the length of residence. Although the early stage (roughly one to two years after immigration) of adaptation in the United States is most stressful for Korean immigrants because of financial difficulties, language barriers, family conflicts, and social isolation/loneliness, the majority of the immigrants have overcome most problems involving language, job hunting, social estrangement, and culture shock with longer residence. However, Korean immigrants who have been in the United States longer than ten years and have secured a good professional career, continue to feel unhappy or feel their lives to be meaningless. They may also experience the "glass ceiling" phenomenon and institutional racism in their work environment. Their social marginality in their adopted country which refers to the precarious condition of social existence of minorities in a given society has painfully been realized (Hurh, 1998). Typical problems include racial prejudice and discrimination, identity problems, and marginality. They may realize their social marginality and their precarious condition as minorities in the United States (Min, 2006; Portes & Rumbaut, 2006; Uba, 1994).

Further distinctions can clarify the stress of immigration. Immigration may be a status loss event for some immigrant men who often have privileged social statuses in their countries of origin, but not for immigrant women who often have lower social statuses than men before

immigration. Consequently, men appear to be more vulnerable to economic and employment related stressors (Thoits, 1995). Assuming that immigration influences financial and occupational status mainly among men (as the main bread-winners in many cultures), their mental health will deteriorate faster than women's mental health following immigration. Mental health of some immigrant women may be better than their male counterparts, drawing upon the hypothesis that women did not participate as actively in financial and occupational activities in their countries of origin. These phenomena may provide suggestions for future research on how to theorize different subgroups' potential coping reactions to stressors. For example, as discussed, men may be vulnerable to financial and occupational stressors, while women may be vulnerable to family relationship related stressors since they are usually the primary caretakers within family groups, and they lose their kinship or family support networks when leaving their home countries. Consequently, reaction to stressors (e.g, coping strategies) may differ by different immigrant sub-groups (e.g., immigrant men vs. immigrant women). It would be valuable for research in the future to formulate and test hypotheses with a number of different immigrant groups.

Coping resources and coping strategies among immigrants

There has been limited research to identify ways to assess coping resources and enhance coping strategies and styles among immigrants. Immigrants might lose established social networks and support as they leave their countries of origin. In addition, given many new challenges to face, immigrants might lose their coping resources, such as self-esteem. Immigrants may have previous competent coping strategies and styles compatible to the circumstances of their countries of origin. In post-immigration circumstances, they may have to revise both coping strategies and styles to fit new contexts. As previously discussed, immigrants' locations in the social structures may change following immigration. Consequently, it is reasonable to expect an adjustment of coping approaches and behavior may be necessary. Given limited research on coping strategies and styles among immigrants, conjecture in this area may be a fruitful direction for improving health promotive intervention strategies for immigrant groups.

As discussed in the previous section on coping strategies, perceived situational control may be related to whether or not coping works effectively. Here, I raise a question related to

immigrant populations: “Which circumstances are perceived as controllable or uncontrollable among particular immigrant groups?” and “which circumstances do immigrants perceive to be more controllable than their US- born counterparts?” We need to learn more about the subjective appraisals that immigrants have of their circumstances. These questions function as potential foci for future research on coping strategies and the best way of enhancing them for immigrant populations.

Thoits (1995) presented a key question on coping research in the discipline of sociology, and that is whether coping techniques and/or coping styles are distributed unequally by social status. I would like to raise a similar question but apply it to immigrant populations: “Are coping strategies and styles distributed unequally by immigrant statuses (i.e., immigrant vs. US-born and immigrant by choice vs. refugee), and pre- or post-immigration social status?” More specifically, we could ask “Are coping styles any different among immigrants than they are among US-born individuals given similar sociodemographic characteristics?” Answers to these questions are promising in the intervention field, because if immigrants’ coping strategies do not differ from those of their US-born counterparts, some of the intervention technology we have already tested may be helpful in promoting the health of immigrants. We need to be cautious in assuming that immigrants are always or somehow qualitatively different from non-immigrants.

Contextually sensitive approaches to the stress process model among immigrants

Contextually sensitive approaches to the stress process model recognize that immigrants are situated in diverse contexts (i.e., historical, developmental, and social), and these may influence the stress process among immigrant populations. For example, the mechanisms linking stressors, coping resources, and social support among immigrants may differ depending on the social contexts in which immigrants settle: the difference may exist between immigrants who settle in ethnic enclaves and those who settle in the areas where other ethnic groups reside primarily (e.g., white-dominant suburban areas).

The differences caused by where immigrants settle can be examined by looking at ethnic density effects. The ethnic density effect can be described as “a phenomenon whereby adverse mental health outcomes among individuals from ethnic minorities are greater in neighborhoods where they comprise a smaller proportion of the population” (Whitley, Prince, McKenzie, & Stewart, 2006, p. 376). A few studies do demonstrate that living in an ethnically dense

neighborhood can be an important correlate of mental health. In a national community survey of over 5,000 ethnic minority persons and about 2,900 white respondents of England and Wales, Halpern and Nazroo (2000) find modest but statistically significant positive associations between same ethnic group density and less reported psychiatric symptoms. Boydell et al. (2001) surveyed respondents who had contact with psychiatric services during 1988-1997 in 15 electoral wards in Camberwell, South London and found significantly increased incidence rates of schizophrenia among ethnic minority groups as the proportions of such minorities in the local population fell. In a locally based study looking at all ethnic groups in South London, Neeleman and Wessely (1999) found an association between same ethnic group residential density and suicide among all ethnic groups (including white people), after controlling for gender, age, socioeconomic status, and migration. In a recent study focusing on the Hispanic elderly group (3,050 Mexican Americans aged 65 years or older in five southwestern states in the U.S.), each 10% increase in Mexican American density in the neighborhood was associated with a -0.548 unit decrease in a CES-D depression score (Ostir, Eschbach, Markides, and Goodwin, 2003).

However, the research remains inconsistent. Some studies have led to different conclusions, finding no significant association between ethnic density and mental health outcomes. In an old national study in England looking at schizophrenia among immigrants, Cochrane and Bal (1988) found that there was no relationship between same ethnic group density and schizophrenia. Henderson et al. (2005) found that CES-D score was associated positively with ethnic density (i.e., percentage of black people in the census block) among both black and white participants before controlling for individual and neighborhood socioeconomic variables. This negative ethnic density effect related to depression disappears once individual and neighborhood socioeconomic characteristics are taken into account. The available evidence does not support a uniform pattern across various studies in the associations between ethnic density and mental health, although the majority supports a positive ethnic density effect on mental health outcomes. Furthermore, there has been little empirical research on ethnic density and mental health outcomes specifically among immigrants.

In addition to social contexts based on ethnic density, diverse contexts may have unique impacts on immigrants' mental health. The following are specific examples of diverse contexts that immigrants may confront: (1) historic immigration contexts, for example, the circumstances

of exiting the home country that refugees and voluntary immigrants may experience differently, and the type of reception (hostile or welcoming) that immigrants may feel; and (2) developmental context: age of immigration (e.g., whether immigrants come to a new country when they are children, adolescents, young adults, adults, or elderly).

Targeting and tailoring?
Contextually sensitive health promotion strategies for immigrant populations

Thoits (1994) general stress process model and its applicability to immigrant populations were examined as a theoretical basis for developing contextually sensitive health promotion intervention for immigrant populations. Based on investigations conducted in the previous sections, specific strategies of contextually sensitive health promotion interventions for immigrant populations will be proposed in this section.

A population-level targeted approach

"Targeting" can be understood as focusing on general demographic characteristics without particular regard for diversity at the individual level (the traditional population-level public health strategy). A targeted population-level approach is capable of identifying and reaching specific populations. A targeted approach implies the process of identifying a population sub-group for the purpose of insuring that it is exposed to the intervention.

Health promotion interventions using a targeted approach provide general education to expose an entire targeted population to new health information, reducing barriers to health care (e.g., language or cultural barriers). Developing culturally sensitive and consistent materials for health education is one of the core components of a targeted approach to health promotion interventions for immigrant populations. There is a definite need for health promotion materials in different languages because some immigrant populations may not be able to understand materials written in English. Health promotion interventions can utilize translation services as a targeted approach for ethnic groups using languages other than English.

In addition to language-related identification, cultural aspects of different ethnic groups need to be considered in developing and implementing health promotion interventions. For example, targeted intervention strategies for immigrant populations also involve changes in

presentation styles to connect with the values, cultures and norms of the general targeted immigrant populations. Health promotion intervention programs may use drawing, pictures, videos or music, applying specific cultural aspects as a way to convey program content efficiently and maintain participation from targeted populations.

Specific strategies to sustain health promotion intervention can also be gleaned from generally available literature on health. First, using empowerment strategy is another way to maintain participation from targeted populations, demonstrate respect for an individual's own decision-making process, values, cultures and norms. Involving immigrants' community members in the planning, design and delivery of interventions is suggested to make health promotion interventions efficient. Second, employing community leaders as "link leaders" (e.g., community health worker models) is also recommended for sustaining health promotion interventions in the community. Third, health promotion interventions should be dynamic because immigrants' values, beliefs, and attitudes change as part of their adaptation to a new country.

The limitation of this population-level targeted approach is that it assumes that individuals in the targeted population share certain characteristics and face similar challenges and needs within that group. In reality, however, individuals in the sub-group vary in terms of personal characteristics, family contexts, and the locations in which they reside. For example, consider a health promotion intervention for recently immigrated Chinese, Vietnamese, Filipino or Korean women. Some of the women are targeted based on their same ethnic backgrounds might have higher socioeconomic status, while others might have lower socioeconomic status. They might be married, widowed, divorced, separated or unmarried. They might be employed, unemployed or temporarily on leave from a job. They might experience financial stress or be financially satisfied. Therefore, to meet the needs of a variety of individuals who possess different personal characteristics and face diverse contexts, targeted approaches may not suffice. Rather, approaches should be tailored to an individual. Incorporating tailored individual-level approaches would provide a deeper and more effective strategy to health promotion intervention programs.

Incorporating a tailored individual-level approach

In this paper, I use the term "tailoring" to refer to activities that identify and focus on

individual-level differences and needs occurring within the broader, general demographic category. That is, individual coping resources and styles interact with specific contexts in which individuals live. For example, personal resources (e.g., sense of belonging, self-esteem) and social resources (e.g., family and friend support, social cohesion in the neighborhood) interact with the various contexts in which individuals live (e.g., supportive extended family contexts, ethnic enclaves). Personal and social resources influence the adaptive outcomes, such as individual health outcomes, of immigrant populations.

A tailored, individual-level approach takes a person's total social ecology into account. Specific tools for incorporating a tailored approach may include developing health messages and materials that are consistent with characteristics, needs and cultural beliefs of specific individuals. For example, in addition to general health information disseminated from a targeting population-level approach, specific training in coping strategies and skills for particular circumstances of individuals can be offered through a tailored individual-level approach (e.g., providing coping strategies that are specifically tailored for Korean immigrant women who have recently immigrated and are married living with children, looking for work, and experiencing financial stress).

Conclusion

A number of concepts from existing social science studies by Thoits and others may serve as useful foundations to improve health promotive interventions for immigrants. Several directions for helpful future research on this topic have been raised in this paper. Existing health promotion intervention programs may benefit from combining both targeted and tailored intervention strategies to promote long-term health and optimal functioning of immigrants. Furthermore, future health promotion efforts will benefit from targeting and tailoring services for immigrant populations, an important and growing segment of the American population.

(5,514 words)

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