Caring For The Bicultural Family: The Korean-American Example

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Bicultural families are increasing in US society, and family physicians will see more of these families for medical care. They can exhibit problems unique to their bicultural experience that arise from the stresses caused by cultural differences in such areas as family roles, emotion expression, child rearing, interpersonal relationships, and methods of communication.

If coping mechanisms do not resolve these stresses, the family will come to the family physician with physical manifestations of illness or distress. The symptoms are usually related to depression or depressive equivalents. To care for these families successfully, family physicians should treat both family members and the individual patient.

When caring for bicultural families, it is important to recognize the high-risk factors that put them at risk for dysfunction. Treatment goals should be centered on communication and education. In short-term counseling, support, education, listening, and referral to appropriate community resources are useful treatment modalities. (J Am Board Fam Pract 1993; 6:261-268.)

Family physicians translate knowledge of medicine and families into management plans for individuals and families. Few, however, know the special issues of caring for a family in which the spouses come from two different cultures — the bicultural family. In this report bicultural refers primarily to US-born–foreign-born couples, but it can also apply to couples of different US cultures, e.g., African-American–white, European descent-Hispanic, and Italian-American–Irish-American.

Between 1960 and 1983 there were more than 500,000 bicultural marriages between American servicemen and foreign nationals.[1,2] In addition, the number of nonmilitary people marrying foreign nationals is increasing, as is intermarriage among cultural groups within the United States.[3] Family physicians will see families from this growing sector of society who have both health and relationship problems.

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Although foreign-born spouses have culture-specific problems, they share many problems common to other bicultural marriages. This article explores those commonalities by focusing on one bicultural example, the Korean-American marriage. There are between 60,000 and 100,000 such couples in the United States, with approximately 3000 new marriages each year.[1] Most of the Korean spouses in these marriages are women, as is true for most foreign spouses in American bicultural marriages. Consequently, we will refer to the foreign-born spouse as a woman.

Our purpose is to explore cultural differences affecting the attainment of a functional relationship, the specific issues in Korean-American marriages, how these issues express themselves to family physicians, and how family physicians can help these families.

The Marriage Relationship

Marriage is complex and dynamic, and it includes transferring identities to the new family, making or breaking obligations to parental families, and realigning with peer groups. The partners' images of the ideal marriage, spouse, and marital roles come from their original families and cultures. Marriage can be viewed as a relationship in which two people, starting at different points, learn negotiation strategies and restructure their roles to achieve family equilibrium. In bicultural

marriages starting points are usually further apart, and individual cultural expectations and goals might not be shared. The bicultural couple must do more learning, negotiating, and restructuring. Thus, bicultural families not only have the usual stresses that unicultural families have, they also must find methods to address those stresses.

The Korean-American Example

Cultural differences are addressed first. Some of what follows is specific to Korea; some can be generalized to other cultures, particularly Asian.

A society's culture provides socially acceptable ways of meeting needs. It sets the value system, defines what is good and correct, and provides common modes of expression and communication. Culture defines family structure, acceptable spouses, member roles, life stages, and rites of passage.[4,5]

Table 1 displays general differences between mainstream Korean and United States cultures. The table is not all-inclusive, nor does it represent everyone in the two countries, because each country is heterogeneous. But each country also has a mainstream culture, particularly Korea, where cultural homogeneity is high. The two countries are not completely different, either. There is some cultural overlap, but the degree of overlap is not great.

In Korea marriage is a union of families, not individuals.[7] Family approval is crucial, and with many marriages parentally arranged, the societal predisposition is to disapprove of marriage outside the Korean culture.

In-laws, especially the husband's family, occupy an important position in Korean marriages, and extended families are commonplace. Such extended families entail a group, not individual, identity. For Koreans, an individual's identity is not complete apart from his or her family, and cultural norms include group conformity and loyalty, deference to authority, and filial piety.[4,8] Maintenance of the family is an end in itself; a wife's self-respect is dependent on the family's integrity, and children are expected to support their parents.[9] This outlook contrasts with the give-and-take equality of individuals within American families.[4]

Korean possessions are communal; American possessions are individual. Instead of the rigid and vertical family roles in Korea, American family

Table 1. Mainstream Cultural Differences.*

Cultural Mores	Korea	United States
Outlook	Relativism Security oriented	Good versus bad Freedom oriented
Communication	Nonverbal, nonphysical Indirect, covert	Verbal, physical Direct, overt
Age orientation	Elderly	Young
Parent-child relationship	Prolonged dependency Parent centered Permissive Obedience demands	Hastened independence Child centered Restrictive Friendliness demands
Living arrangement	Extended family Little geographic mobility	Nuclear family Geographically mobile
Family outlook	Filial piety Vertical, rigid relationships Communal possessions	Individual responsibility Horizontal, flexible relationships Individual possessions
Time concept	Leisurely	Punctual
Interpersonal relationships	Conformity Harmony Gender-separate activities	Individualism Competition Gender-combined activities
Sexual behavior	Defined, regulated	Open, less inhibited
Food	Spicy Reliance on rice	Cheese, greasy, Reliance on meat

*Information in this table was adapted from the Department of the Army,[1] Lee,[5] and Bowen and Henley.[6]

roles are relatively horizontal and flexible. The nuclear family, not an extended one, is the US model. Independence and youth are revered in the United States; filial piety and maturity in Korea.

In marriage the Korean wife assumes a submissive, subordinate role, but she expects to be responsible for family finances and child rearing. She expects her husband to be the wage earner, head of the family, and major decision maker.

In dyadic relationships Koreans strive to maintain smooth ties, design answers to please rather than express authentic feelings, and handle conflict by avoidance and accommodation.[4] Americans tend to competition and individualism. The Korean asks, "What does the other person want to hear?" The American asks, "What do I want to say?"[4] This aspect of Korean culture encourages indirect communication and suppression of feelings, whereas in the United States communication is more direct and overt.

There are other cultural differences that affect the marriage: Korean women express affection less openly.[1] American couples attend recreational activities together, but Korean spouses usually have sex-specific friends and activities. Americans depend on private cars; most Korean women do not drive.

As a result, the foreign-born spouse who is competent and functional in her own country can become in the United States dependent on others for many daily activities. It becomes the husband's responsibility to help his foreign-born wife learn community values, accepted patterns of relationships, and appropriate responses to stressors. To do that, he must perceive and interpret both cultures, an uncommon ability.[2] Because methods of communication and expression are different, the American husband might not even know what his foreign-born wife thinks or feels.

From these cultural differences emanate specific, recurrent issues in Korean-American marriages. Table 2 presents a temporal list of these issues. Note that the problems differ with the family's life cycle and length of time in the United States.

The American husband often expects his foreign-born wife to be fluent in English and to be fully competent in daily US life.[7,11] Everyday tasks in the United States for a native-born individual, however, can be major tasks for someone from another culture, e.g., banking, shopping on credit, and driving. Combined with less-than-fluent English, this lack of complete ability to function makes the wife dependent.[9] Unable to func-

Table 2. Major Problem Areas in Bicultural Families (Listed in Order of Decreasing Frequency).

Premarital*	Newlyweds in Wife's Country	In United States: First Child in Grade School*	In United States: All or Most Children in Teens
Language	Language	Spouse separation	Communication of feelings
Food	Support of wife's family	Recreation	or values
Religion	Wife's anticipated adjustment	Loneliness	Bicultural children
Family lifestyle	to United States	Wife's separation from her	Friendship circle
Citizenship	Communication	family	Where to live
Wife's adjustment to	Bicultural children	Wife's use of time	Recreation
United States	Racism	Wifes education	Spouse support if husband
Wife's employment	Friendship circle	How to seek help for marital	dies first
In-laws	Homesickness	difficulties	Racism
Bicultural children		Fatigue	
Racism			
Customs and traditions			
Communication			
Money management			
Culture shock			
Homesickness			
Acceptance by family			
and friends			
Friendship circle			

*From Radasky[10]

tion adequately in her new country, she can lose self-esteem and become even more dependent. This increased dependency can anger the husband and frustrate the wife.

Conversely, the husband might expect his wife to be the same person she was while in her country. Upon arrival in the United States, she could so fully adopt American ways that she changes to an extent that her husband cannot relate to her.

The narrowing of human interaction for the entire bicultural family is a concern. Cultural proscriptions against extracultural marriages and racial prejudice in both countries can cause communities to ostracize the new family.[12] The bicultural family might not be fully accepted by either society of origin. Even unicultural Korean families in the United States shun Korean women married to American men. The husband's old reference group might no longer accept him, or his new experiences might prohibit him from rejoining that old group. Often the only friends of many bicultural families are other bicultural families, and some bicultural families have no coupled friends.[13] As a result the family can become cut off from usual support systems: parental family and friendship networks.[1]

Without the usual support networks, bicultural families turn inward. With different cultural modes of communication, however, needs and expectations can be misinterpreted, not communicated, and unmet.[4] Even though love exists, functional communication of it might not exist. Many intended expressions of love and support are lost if the recipient is not aware of the cultural modes of those expressions. For example, a Korean wife might express love by dependence and passive listening rather than expressing empathy overtly. Conversely, an American husband might express love by enlisting joint decision making and giving factual advice rather than listening.[4] The possibilities for misunderstanding are obvious.

The focus of the new family's primary loyalty in the new family or in parental families is another issue. Asian wives are expected to support parental families. More than one-half of Korean spouses of US Army husbands have brought their relatives to the United States.[14] Many reside for some time with the bicultural family, a situation not always expected or fully accepted. Minimally, Korean wives might want to support parental families monetarily, an obligation that could frustrate and anger their husbands. On the other hand, the husband who does not acknowledge his wife's cultural responsibility to her parental family can foster guilt and shame in the wife and increase the emotional distance between her and her parental family.

Child rearing is another frequent issue. A Korean wife might want to foster group loyalty and submissiveness in her children; her American husband might seek to encourage initiative and independence.[4] Another question is whether the foreign-born mother can adequately help her children with schoolwork and with problems adjusting to typical and uniquely American situations. During normal adolescent rebelliousness a foreign-born parent can be viewed as being from not only another generation but also from another country — an outsider.[15] Asian mothers can react more intensely to this adolescent parental rejection, as such rebelliousness is not so overtly experienced in Asian cultures.

Family roles can be a source of contention. The husband could expect active participation by his wife in family decisions, while she might not want or expect it. As a result, the two spouses can assume parallel but separate roles within the family that limit their sharing of ideas, roles, and emotions.[4]

Lastly, if the husband and wife observe and practice separate religious beliefs, there is another issue in which the couple is limited in sharing and in which they must negotiate a functional relationship. Of note is that 40 percent of Korean-American couples have different religions.[1]

All of the above issues, e.g., communication methods, family orientation, relationships to children, and approach to interpersonal relationships, point to areas in which cultural differences can be extreme. The more distance to overcome between the two cultures in these areas, the more difficult it is for bicultural couples to adapt successfully to marriage.[12]

Manifestations of Stress and the Family Physician

The effects of stressors depend on the coping mechanisms of the individuals and the family unit. At one extreme is the adaptable family that seeks care from the family physician only for acute illnesses and health maintenance. At the other extreme is the foreign-born spouse who retains most of her traditional ways, who speaks English poorly, whose children are all-American, and

whose husband is absorbed in work. She never goes out, cooks separate, ethnic meals for herself, and has no support network. Between these two extremes are the vast majority of bicultural families. They cope with most problems but might not successfully cope with all of the accumulated stresses that come in close association. These unresolved stresses can cause psychosocial, behavioral, and physical symptoms.

Sometimes these stresses are expressed through anxiety, substance abuse, and domestic violence. The most common presentation of stress-related problems is depression or depressive symptoms. Depression is the largest single diagnosis in foreign-born spouses complaining of an illness.[15] When family physicians encounter a foreign-born patient who exhibits signs of depression, they should also inquire about fears of infidelity, anger, intolerance of children, and increased use of alcohol or nicotine. It is easy to understand how the loss of friends, family, competency, and a social identity can combine with the anxiety of dealing with new value systems, meeting new in-laws, living in a new country, and experiencing social isolation and lead to guilt, anxiety, and depression.

Many somatic complaints are culturally based and all societies have culturally appropriate expressions of physical and emotional pain. As examples, Koreans frequently complain of gastric distress or fatigue, Germans complain of "heart insufficiency," and the French complain of "liver problems."[16] A corollary is that foreign-born spouses might view American medicine and physicians in a way that differs culturally from the way Americans view the medical establishment. These cultural differences influence the physician-patient interaction in communication, diagnosis, advice giving, and treatment goals.[8]

The Korean-American example illustrates this well. Can the foreign-born spouse adequately verbalize problems or understand physician questions and advice? Asian women are usually passive and do not readily question an authority figure, i.e., a physician. In the Korean culture authority tends to be autocratic; women expect physicians to be more directive than democratic in treatment decisions.

In Asian cultures the extended family is depended upon to help with nonphysical problems. Not only are Asians not accustomed to revealing personal or family troubles outside the family, they also do not expect physicians to help with family or psychosocial problems and will be surprised when their family physician explores those areas. Such women will not readily divulge these matters and will try to keep the interview turned to somatic complaints.

Other culture-specific examples of medicine include the Korean mother who expects an injection for a viral upper respiratory tract infection, who shaves her child's head to increase hair growth, and who has already tried herb medicine or acupuncture.

It is not only the foreign-born spouses who seek out their family physician with somatic expressions of distress. American husbands can experience much of the same distress, but they are more likely to complain of decreased work efficiency or alcoholism.[15]

Children can also come to the family physician with symptoms of depression, many of which are different from those of adults. The most common complaints are abdominal distress, sleep disturbances, headaches, changes in activity, moodiness, and school problems, but how a child expresses depression depends on the developmental stage of the child.[17]

Preschool children might be brought to the family physician for regression, developmental delays, or nonspecific eating complaints. School-age children might complain of racial remarks at school and be confused about racial identity. The astute family physician should also be alert to lack of well-child visits for children of a foreign-born mother who is not aware of immunization schedules or who is isolated and without transportation.

In short, the recurring questions for bicultural families could be (1) for individual members, "Who am I?" and (2) for the family unit, "Where do we belong?"

Treatment Strategies

Recognition and prevention of potential stressors is the first step in management, which is made easier by looking for risk factors of inadequate coping (Table 3). Many risk factors are associated with family transition times, e.g., moving to the United States from the wife's native country or retirement. Other risk factors can be associated with events in which the absent extended family would normally assist, e.g., childbirth and illness,[15] individual characteristics (poor English language ability or being the eldest child), and

Table 3. High-Risk Factors for Bicultural Families.

Premarital factors
Poor English ability of foreign-born spouse
Foreign-born spouse is an eldest child
No premarital preparation classes
Younger couple
Marital factors
Poor acceptance by American in-laws
American spouse reluctance for foreign-born spouse to associate with native countrymen
American spouse fears that foreign-born spouse will become "too American"
Change factors
Recent arrival in United States
Recent arrival of foreign in-laws in United States
First pregnancy
New retirement
American spouse away from home for first time

being a young couple with less experience and fewer coping skills. All risk factors relate to the family's particular life-cycle stage.

As noted, bicultural stresses are often reflected in physical symptoms. If misinterpreted, these symptoms, rather than the underlying psychosocial problems, could become the focus of attention. Family physicians skilled in eliciting psychosocial aspects of complaints are more apt to recognize bicultural stresses. Look for depressive symptoms and evaluate family relationships. Instruments others have used to evaluate families include family trees, family circles, family interviews, activity groups, and reviewing earlier, change-related adaptation behavior.[18]

When a problem is recognized, the bicultural family should be targeted for care, not just the patient. The treatment goal depends on the family's needs, capacities, and motivation.[2] The family physician's role will depend on the physician's skills and interest in family intervention. The family physician who does family therapy can act as facilitator to enable cultural understanding, communication, skill development, and removal of systemic constraints.

For the family physician who does family counseling rather than therapy, suggested methods are active listening, education, support, modeling, and rehearsal.[2] Two techniques found useful in this setting are the LEARN technique described by Berlin and Fowkes[19] and the BATHE technique described by Stuart and Lieberman.[20]

Each spouse moves toward the other's culture, but the extent to which each does varies with each couple based on the family's identified needs. The goal is to have the couple reach a common point in which they are comfortable and functional, a family cultural balance.[8] Although the goal might not be to change behavior, it should at least be to help members become aware of their behavior and its meanings. The family should learn to appreciate each family culture and accept and interpret behaviors as culturally appropriate.[4] It is okay not to dissolve all cultural differences.

To fulfill needs, family members must be able to communicate them, but bicultural families often need help finding ways to communicate their needs.[21] Members might need to learn each other's culturally specific cues and to focus on indirect communication and meanings rather than how the communication looked. For example, it is not appropriate to equate the nonexpression of emotions in Asian women with the absence of those emotions.[2] Communication will still be culture-bound, but the treatment goal is to make communication functional so that family members can work toward fulfilling their needs and solving their problems.[4]

Other assistance might be pointing a newly arrived spouse to the department of motor vehicles for a driver's license or to local English language classes. It could involve suggesting support resources, such as culture-specific churches and secular associations. These two resources can also be potential sources for an interpreter or a cultural broker. A cultural broker is that rare individual who understands both cultures well, who has bridged the differences between them, and who can live comfortably in either one. A cultural broker is hard to find, so family physicians will often care for bicultural families without such services. In doing so, there are some caveats to remember.

First, the family physician does not need to be from a particular culture to help someone from that culture. Requirements are ethnosensitivity, community networking, a transcultural outlook about health and illness beliefs, an awareness of cultural differences, and an ability to learn about another culture and to adapt helping and counseling behaviors. Family physicians should be aware of both the patient's tendency to view the physician in her own cultural image of a physician and of the physician's tendency to respond to the patient in terms of ethnic stereotypes.

Family physicians without training in these areas must distinguish sociocultural differences from psychiatric abnormality.[8] If a spouse is from a culture of constrained expression, give that spouse more time to respond. Do not explore feelings and emotions right away. Trust comes first, and the physician might have to wait until the foreign spouse broaches the troubling subject. In some cases, the counseling approach itself will have to be explained to the spouse.[10]

Next, if the foreign-born spouse is from an authoritarian culture, the insight-oriented, cathartic approach might not work. The family physician might need to be more educational, task-oriented, paternalistic, and directive.[10]

Assume that spouses new to the United States are apprehensive. They will need help understanding the US medical system. Empathetic office personnel, culture brokers, or cultural support groups can help. Make advice and explanations culturally relevant and avoid technical language. Assess a foreign-born patient's understanding of instructions.

Marital counseling can work only if both spouses are invested in it. When one of them is not, the family physician will treat only the individual patient, not an infrequent occurrence in bicultural families. In severely dysfunctional marriages, an alternative is to explore the possibility of divorce. For Asian-born wives, however, for whom marriage often defines the woman, divorce is inferred as a personal failure and will not be readily explored.

Many family physicians have the interest, ability, and resources to care for bicultural families. For other family physicians, their resources can be overwhelmed by the needs of these families. When such is the case, consultation and referral are indicated. For example, the family could need intensive therapy, the physician might not feel comfortable without a language proficiency, or the patient could need education in parenting, financial skills, coping skills, American culture, and English language.

It helps to develop a list of interpreters and cultural brokers. The nearest ethnic organization can help. If the family physician's office is located near a military installation, its family services branch can be an excellent resource. The focus is to discover the community resources that can assist bicultural families.

Summary

One distinction of family practice is its willingness to deal with problems of family functioning. Family physicians are taught to understand the needs of both individuals and families. Caring for bicultural families highlights these principles of family-oriented care.

Most bicultural families are successful in their relationships and function well as families. Many of their needs are the same needs of all families. Nevertheless, bicultural families also have special stresses and needs. The family members are trying to establish their roles both in their own family and in a culture foreign to at least one of them.

Individuals and families who do not cope well with these stresses can seek care from the family physician for resulting stress-related symptoms. These symptoms and stresses are family based and should be dealt with as a family problem. Family physicians should try to understand the dynamics of bicultural marriages, be sensitive to the special circumstances and needs of bicultural families, and be prepared to play a central role in helping and supporting them. It is important for family physicians to recognize the depressive symptoms of which foreign-born patients complain and to be aware of families at higher risk for inadequate coping skills.

Treatment goals are centered around establishing effective cross-cultural communication that allows fulfillment of normal family needs.[4] Family physicians are frequently the initial points of contact in the health care system and the gatekeepers for bicultural families. The emphasis of primary care counseling for bicultural families is on active listening, education, and physician sensitivity, with appropriate referral and encouragement to use community resources. Successful care for bicultural families represents the best in family medicine.

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