

OVERCOMING THE BARRIERS TO MENTAL HEALTH TREATMENT

SERVICES IN KOREAN AMERICAN POPULATIONS:

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ABSTRACT

This study examined the experiences of Korean Americans who had gone through the process of considering entering therapy. Eight participants (ages 25 to 35; 6 females, 2 males; and 1st and 2nd generation Korean Americans) took part in two to three interviews and completed a survey that assessed their level of acculturation. The interview, qualitative and open-ended in nature, asked the participants to talk about their lives leading up to their first therapy appointment, the obstacles they faced in entering therapy, and the factors that facilitated their first session with a psychologist. The purpose of the study was multifaceted: 1) to discover the ways that Korean Americans are introduced to therapy, 2) to understand the reasons for their reluctance to enter therapy, and 3) to discuss the process of entering therapy, despite their reluctance to go into therapy. Participants sought out more information about therapy in a state of severe emotional distress and during periods of significant life changes. The most significant challenges were the social ramifications the participants anticipated upon entering therapy and their anxieties associated with meeting and communicating their problems to a stranger. The culturally different conceptualizations of mental health and approaches to coping with psychological issues were additional obstacles as were the participants' doubts about the relevance and efficacy of therapy. The results indicated that participants were more likely to enter therapy if their problems were seen as impacting their academic performance or career ambitions, or if their problems were severe and unmanageable. Living in therapy-friendly environments with supportive friends who were participating in therapy mitigated the stigma of mental health; moving away from their parents

empowered them to choose therapy despite their family's potentially negative reactions; and viewing therapy as a form of self-care on par with a medical visit or a yoga practice also helped to overcome their negative perceptions of therapy. In managing the negative reactions of their family and friends, participants were able to pursue therapy. These findings may be utilized to improve the effectiveness of mental health outreach to Korean Americans and to inform clinicians in their work with Korean Americans.

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Chapter 1

INTRODUCTION

Statement of the Problem and Relevant Literature

Decades of Asian American literature have accumulated a large body of evidence on the rates of mental health service utilization and premature termination of services. An abundance of Asian American research studies (Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Kinzie & Tseng, 1978; Loo, Tong, & True, 1989; Snowden & Cheung, 1990; Sue & McKinney, 1975; Sue & Morishima, 1982; Uba, 1994) have discovered that Asian Americans on average participate in mental health treatments at comparatively low rates, even among ethnic minorities, with a large percentage of participating individuals terminating prematurely. Of these studies, Korean Americans were categorically identified as the least likely ethnic subgroup to enter a mental health treatment setting among the 21 unique Asian American ethnic groups compared. Several community profile studies (Kim-Goh, 2005; NY PROFILE) in the U.S. have discovered a significant percentage of Korean Americans reporting a heightened degree of psychological distress; and a disproportionate percentage of Korean Americans whose psychiatric illnesses have remained untreated and undiagnosed.

Multicultural counseling researchers (Atkinson & Gim, 1989; Gim, Atkinson, Whitley, 1990) examined the impact of help-seeking attitudes and the willingness to meet with a practitioner in an effort to identify the factors associated with higher mental health service utilization and compliance rates among Asian Americans. Several studies (Akutsu, Snowden, & Organista, 1996; Lee, 1988; Narikiyo & Kameoka, 1992) have found that Asian Americans are likely to seek support from their family members and

friends when they are incapable of managing the mental issues on their own; however, when their efforts do not ameliorate the severity of their issues, Asian Americans rarely seek the support of community figures such as elders and spiritual leaders and may only consider professionals outside of the family as a last effort. And of these study samples (Chun, Enomoto, & Sue, 1996; Zhang, Snowden, & Sue, 1998), medical doctors were the overwhelming favorite among the professional support services, with somatic complaints accounting for the majority of problems reported.

Attitudes towards help-seeking are significantly influenced by the levels of acculturation (e.g. the extent to which individuals adopt values from the dominant culture; Kim, 2007) and enculturation (e.g. the extent to which individuals maintain and retain the cultural values and traditions from their country of origin; Kim, 2007). More highly acculturated Asian Americans were found to express more positive attitudes toward seeking psychological services (Atkinson & Gim, 1989; Tata & Leong, 1994) and demonstrate more help-seeking behaviors (Ying & Miller, 1992). Traditional Asian values emphasize emotional self-control, conformity to norms, and family interdependence. Asian American who expressed a psychological problem could have been chastised and shamed by family members, as it was a disgrace and a sign of weakness to talk about one's personal problems outside of the family. It was viewed as an affront and a violation of the family's privacy and, therefore, deserving of shame.

A study by Kim and Omizo (2003) found a negative correlation between the attitudes toward seeking psychological help and the enculturation level of Asian American college students. Students who have lower enculturation scores were found to be more emotionally withdrawn and socially isolated compared to their more acculturated

counterparts. They were also more sensitive to social rejection and tended towards a passive, non-confrontational style of communicating with others. Communicating, especially with parents and authority figures, was considered challenging among these individuals as a person in the position of power was perceived to be inflexible and domineering. Therapy was likely to be of less interest to an individual who felt threatened by talking about problems and relying on another person. Thus, the low rates of mental health utilization among Asian Americans seemed partly attributed to one's style of communication.

Several community profile studies have gathered epidemiological data on the prevalence of psychological disorders among Korean Americans and, through focus groups and interviews with Korean Americans in community centers, identified several challenges to accessing and utilizing mental health services. A community profile from Orange County, CA (Ahn, Kim-Goh, Shin, & Wee, 2008) has evidenced an ever-widening divide between reported psychological distress and the underutilization of mental health services. This Korean American sample reported a higher frequency and severity of psychological distress than the regional average while they also reported significantly low utilization rates of mental health treatment services, which were attributed to cultural discrepancies and physical barriers, e.g., finances, insurance, etc. Consistent with the research literature on the barriers to mental health treatment services among Asian Americans, this seemed to be an issue of misinformation, differences in the values and beliefs between traditional Asian and American mainstream cultures, and physical limitations.

Purpose and Significance of the Study

The current study sought to understand the decision-making processes of Korean Americans who were considering the option of going into therapy. Based on the narratives of eight Korean Americans, which detailed their lives leading up to their first therapy appointment, this study examined the factors that discouraged them from entering therapy as well as those processes that led them into the psychologist's office. The purpose of the study was multifaceted: 1) to discover the ways that Korean Americans are introduced to therapy, 2) to understand the reasons for their reluctance in entering therapy, and 3) to discuss the process of entering therapy in spite of their reasons for not wanting to go into therapy.

In order to qualify for this study, prospective participants were required to be of Korean descent, at least 18-years old, and residing in the U.S. for a minimum of one year at the time of the interview. Additionally, Korean Americans with professional affiliations to the mental health industry, e.g., clinical and applied psychology, marriage and family counseling, clinical social work, etc., prior to their entry into therapy were excluded from this study. This minority of Korean Americans was likely to have an idiosyncratic perception of therapy not shared by the average Korean American mental health consumer because their therapy involvement could have been a requirement in the training. Additionally, Korean Americans in the mental health industry have a positive impression of therapy, enough to pursue it as a career. For these reasons, these Korean Americans were excluded from this study.

The participants' narratives were gathered via an open-ended interview, one in which themes related to the topic emerged organically throughout the process of a

curious inquiry. The interview guidelines and discussion topics were based on eliciting the participants' subjective experiences from this period in their lives. At the end of the interview, the researcher presented a list of common barriers to mental health identified by the Asian American psychological literature and invited the participant to share about those experiences that resonated with his or her life. The mental health treatment barriers identified in these studies provide a useful guide for understanding the possible obstacles that the participants in this study may have faced as they considered therapy. As a part of these questions, this researcher specifically asked the participant to talk about how their cultural identity, e.g., values, traditions, and beliefs, interacted with their interests in going to therapy.

The findings of Asian American psychological studies do not necessarily reflect the experiences of Korean Americans as such studies are likely to be clouded by the heterogeneity of the "Asian American" grouping. As such, the research literature has been indirectly, perhaps out of convenience of an adequate sample size, overlooking the intricate, within-group differences among more than 20 "Asian American" ethnic groups, each with unique detailed histories, traditions, and values. Presently, there are no published studies that have examined this pre-therapy process in Korean Americans. The abundance of literature in Asian American psychology has provided the groundwork for subsequent studies to examine a multitude of issues with greater specificity.

Research Methodology

The focus on phenomenological research is on the subject's experience from the first-person perspective. At the core of any "experience" is its intentionality, the way that it forms and shapes the participant's content and meaning of the object in the world. The

participant's experiences and perspectives within the context of therapy were examined and analyzed by understanding the way in which they structured these experiences, e.g., their perceptions, thoughts, memories, imagination, emotions, desires, and volition to bodily awareness. Phenomenology was understood in this study as a discovery-oriented approach to research, where the participant's "experience" then emerged.

The Grounded Theory approach posits that every person is a product of his or her social construction and that personhood emerges through interactions with the environment, particularly through societal elements, such as languages, forms of communication, and community. Grounded Theory researchers aim to collect their "data" through an open-ended interview, from a curious stance, in which a great deal of intention and awareness is placed on the participants' experience. The "data" from the participants' experiences may become contaminated if the researcher imposes his structure onto the participants via prematurely analyses and interpretations. As such, it behooves the researcher to stay as closely to the participant's experience as possible and be mindful in inserting his or her own beliefs. Once the basic observations of the interview are recorded, the data may be reduced, reconstructed, and re-analyzed for interpretation.

Limitations and Delimitations of the Study

This study is qualitative and exploratory in nature, and its results are drawn from a study sample of eight participants. Each participant brought a unique collection of values, beliefs, and experiences, some of which contributed to their interest in therapy and eventual involvement. The findings from this study do not claim to assert a generalized knowledge of Korean Americans in therapy or a typical process undergone

by the majority of Korean Americans considering therapy. Common themes were identified.

Each participant was involved in a 90-to-100-minute interview on life prior to entering therapy. For some participants, this was as recent as two years ago, while for others, it could have been more than 10 years since they first considered the idea of entering therapy. Retrospective interviews have inherent limitations based on the participants' ability to recall an experience. If a participant was a poor reporter of his or her experiences, e.g., denies and reconstructs them, it could consequently distort the results. There are countless reasons why it may be difficult to accurately recall an experience, one of which is the intensely negative affect, e.g., shame, embarrassment, and guilt, associated with therapy or their mental illness. Talking about why they went to therapy with a graduate student "stranger" was observed as being a challenging and daunting task.

CHAPTER 2

LITERATURE REVIEW

Introduction

The Korean American literature has provided an overview of the process of immigrating to the U.S., their attitudes toward mental health, and their rates of mental health utilization in select regions. The first section of this chapter introduces the three main time periods in which Koreans immigrated to the U.S., an overview of Korean traditional values, and common acculturative conflicts and adjustment issues of recent Korean immigrants. The second section reviews the epidemiological rates of emotional distress and psychological illness among recent Korean immigrants and Korean Americans. Specifically, this section presents the prevalence rates on mood and anxiety disorders, alcohol abuse, psychiatric disorders, and gender specific disorders.

The third section presents existing research on Asian American attitudes towards mental health services as well as a list of common barriers specific to Asian American individuals. Based on the categories developed by Leong and Lau (2001), the barriers are grouped into the following: cognitive, affective, value orientation, and physical obstacles. The fifth section presents an overview of the research literature on Korean American attitudes toward psychological services and introduces traditional Korean values, such as jeong, haan, and noon-chi, to explain some of the challenges that Korean Americans may have with the Western sensibilities of mental health and treatment. Then, this section introduces traditional conceptualizations of mental illness and healing practices, such as shamanism, traditional Chinese medicine, and spiritual practices, e.g., Buddhism and Taoism, all of which may still be used today. The sixth and last section presents the

reasons why there is a need for greater awareness of mental health among Korean Americans and introduces how this study is the first of several pieces to begin in addressing them.

Korean Americans in the United States

Overview of Korean American immigration. The Korean American population in the U.S. has seen a radical growth in recent decades and has continued to be one of the fastest growing ethnic minorities in the country. The U.S. Census Bureau (2000; 2008) indicated that there were roughly 1.6 million Korean Americans in the U.S.; and, among these, 400,000 Koreans entered into the U.S. between 2000 and 2008, a growth that represented a 44% increase during this period.

The Korean American population has been viewed as being one of the largest and fastest growing populations among Asian and Pacific Islander ethnic groups. According to Min (1995), Koreans represented the third largest ethnic group to immigrate to the U.S. in recent years, behind only Mexico and Philippines. Among the major cities in the U.S., Los Angeles, CA contained the largest population of Korean Americans outside of Korea. Palisades Park, NJ, with 36.38% of its inhabitants of Korean ancestry, has the highest concentration of Korean Americans in any one region within the U.S. (U.S. Census Bureau, 2008).

Many U.S. cities that have a strong representation of Korean Americans were near or within major cities, such as Queens, NY, Orange County, CA, and Chicago, IL. Parts of Georgia, Virginia, and Philadelphia, PA have also been found to have burgeoning Korean American communities.

Koreans immigrate to the United States in waves. The rise of the Korean Americans population in the U.S. has been identified by sociologists as occurring in three distinct time periods in which the opportunities to immigrate to the U.S. seemed to be more possible. The first wave, between 1903 and 1924, consisted of contract laborers who were motivated by an economic opportunity in Hawaii. The second wave, between 1951 and 1964, comprised the immigration of orphans who were negatively impacted and displaced after the Korean War. The third wave began with the Immigration Act in 1965, which ushered in a new era of racial and ethnic equality particularly for ethnic groups like Korean Americans whose representation was disproportionately small.

The first wave began with Korean immigrants entering the U.S. between 1903 and 1905. Motivated by the prospects of a higher standard of living, approximately 7,226 Koreans immigrated to the U.S. with opportunities to work as laborers on the sugar plantations of Hawaii. Another 900 Korean young adults and 1,066 Korean females entered the U.S. before 1924 as students and picture brides, respectively. Many of these immigrants were uneducated and semi-skilled, at best, and predominantly male. About one out of ten Korean immigrants was female, a proportion that was still far greater than the Chinese and Japanese immigrants of whom were represented virtually by males.

A notable development during this period was the inception of the Korean Christian church, which flourished as the bedrock foundation for Korean Americans who were seeking support, community, and cultural familiarity. By 1915, more than fifteen Korean speaking churches were built in California, some of which still exist and play an extremely active role in drawing many Korean immigrants. Such religious institutions were particularly vital because it served as a safe place from the discrimination and

prejudice of non-Korean Americans and provided a resource for navigating the complexities of the foreign American culture. Due to the policies restricting immigration to those Koreans eligible to work at the plantations, many immigrants were displaced, isolated, and separated from their families. Their experience of being neglected and displaced was exacerbated by the lack of response from the Korean government, as the Japanese annexation of Korea impeded any diplomatic assistance that could have otherwise been provided to them.

The second wave of Korean immigrants from 1951 to 1964 was a byproduct of the Korean War, with approximately 6,423 Korean women immigrating to U.S. after marrying a U.S. serviceman and 6,293 Korean orphans adopting into American families. An ideological shift had occurred during this period, with many staunch Korean nationalists identified with the U.S. and regarded their values as a means of achieving the nationalist goals of democracy and material affluence. Koreans viewed the U.S. as an ideal model to emulate and aimed to change their country into a similarly Westernized and democratic nation. The idealization of the U.S. also redefined the qualities of “beauty,” a value that has motivated many Korean American men and women to alter their physical appearance to accentuate western features.

The third wave of Korean immigrants (post-1965) has long been considered a product of forced modernization by General Park Chung Hee and facilitated by the reformations in the U.S. immigration laws. Korea’s impassioned adoption of the world’s capitalism and the exportation of goods during the mid-1960s marked a shift in the regime’s policies, which heavily favored business conglomerates at the cost of the lower and middle class, providing tax advantages and monopoly privileges to the wealthy for

their financial contributions to the government. This resulted in the extreme polarization of the poor and the wealthy and weakened smaller scaled enterprises much to the intensifying ire of the white-collared middle class.

Such disadvantages ultimately motivated many middle-class Koreans with professional backgrounds to immigrate to the U.S. Such individuals were conveniently mobile and were likely to have the necessary resources to survive the adjustment and prosper. Many of the Koreans who immigrated during this period were intelligent and skilled. Healthcare professionals, e.g. physicians, nurses, and pharmacists, came under “occupational preference provisions” between 1966 and 1979, which expedited their immigration process to the U.S. By 1970, 70,598 Korean Americans were living in the U.S. By 1980, 357,393 Korean Americans were living in the U.S. And by 1990, there were 798,849 Korean Americans living in the U.S.

There were clear discrepancies in the socioeconomic statuses, education levels, and support systems between the Korean immigrants from the first, second, and third waves. Most Koreans immigrants from the third wave were connected with social supports before they arrived. Compared to other periods when Koreans typically immigrated by themselves, many of the Koreans during this period traveled with their nuclear families. Many Koreans were connected to relatives and/or close friends, who were already settled in the U.S. During this period, many Korean-based organizations, associations, and institutions, e.g. churches, were also well-established, which served to lessen the shock of recent immigrants who moved to the U.S. These variables were likely to serve as protective factors against psychological symptoms, immigration stressors, and the capacity to transition into the foreign country.

Traditional Korean values, Confucianism, and collectivism. Traditional Korean values and identities are based on the fundamental precepts of Confucianism and collectivism (Oak & Martin, 2000). The principles of Confucianism encourage and emphasize educational pursuits, family systems, hierarchical relationships, and benevolence. Similarly, collectivistic values emphasize interconnectedness and interpersonal regard for one's "self." This person is primarily concerned with how their actions will be received by others and the impact that it has on the members of the ingroup, e.g. immediate and extended families, friends, etc. Traditional Korean families tend to be community oriented and minded, in that resources are shared, relationships are interdependent, and decisions and goals are understood from the perspective of the whole (Hui & Triandis, 1986). Those raised in such cultures desired a sense of belongingness with their respective ingroups and felt the most "complete" when he or she was seen by others as functioning smoothly within the larger collective. Traditional Korean values also encourage a "fight and die" mentality to maintain the integrity of the ingroup (Triandis, 1972).

Korean American families are more inclined to share personal information with the public only if it enhances their standing and reputation within the community; otherwise, problems within the family are considered private and withheld others. Being "nice" to ingroup others is a high value, so that one expects in most situations extreme politeness and a display of harmony. Collectivistic cultures place an emphasis on methods of conflict resolution that minimize animosity and promote an emotional self-restraint; as such, public appearance and impressions can be viewed as an extension of the collective self.

The power differential between a parent and a child in a traditional Korean family is pronounced, one in which the parents are authoritarian and the child demonstrates deference and obedience. Thus, the child's individualized needs are minimized and dismissed. The importance of self-renunciation is typically inculcated from an early age. Parents emphasize their expectations for the child to serve and seek the greater good of the family. Children are socialized to the rules of conduct and are taught to seek harmony in all interpersonal contexts via placing their personal desires beneath that of the entire group. Such a pressure can foster a sense in the child that self-effacement and self-sacrifice are positive qualities. Perhaps love and care are given to the child that meets their parents' needs; such pressures weigh heavily on the Korean American child, whose performance is perceived to have a direct impact on the family's reputation and standing in the community. Children, in their limited understanding of their parents' intentions and the relative incapability to delay their needs of gratification may come to resent their parents, which can then precipitate acting out behaviors.

A considerable literature has found that traditionally collectivistic values emphasize deference to authority figures and obedience towards the integrity of the ingroup. This hierarchical style of relating to others, with an authoritarian at the top, becomes the imprint for all relationships in that it acts as a powerful force in determining how one thinks and behaves (Kim & Ryu, 2005 MCG). This dynamic is evidenced by the Korean language, which is nuanced with more than three classes of nouns and verbs that signify a ranking order in relationships (Kim, 1978; Kim & Ryu, 2005 MCG). There are words in the Korean language that denote the inclusivity of a household or the ingroup, such as *Jip-an*. Its literal translation is "within the house," which is emblematic of the

loyalty shared among family members and the exclusivity and privacy within a family unit.

Collectivism promotes close and boundless relationships within the ingroup, e.g., immediate and extended families and ethnic groups; however, it also promotes a detached and distant quality in relationships with members of the defined outgroup. To these individuals, there tends to be a sense of distrust and vigilance. A study by Gudykunst, Yoon, and Nishida (1987) examined the ingroup and outgroup interactions of highly collectivistic countries, e.g. Korea, and more individualistic countries, e.g. U.S., and discovered that the Korean sample was significantly more “personalized” and “synchronized” in their communication among their ingroup compared to their U.S. counterparts.

Acculturation and enculturation among Korean American families. A significant proportion of Korean immigrants in the U.S. have maintained a high level of ethnic attachment (Min, 1990). A majority of Korean immigrants speak the Korean language, primarily eat Korean food, and practice traditional Korean customs; and, thus, have a high level of enculturation. How have Korean Americans been able to maintain such high levels of enculturation over time in the U.S.? Min (1995) has provided three different reasons to explain how a majority of Korean Americans have sustained a strong indigenous ethnic identity and cultural values even after being years removed from their immigration. First, Korean Americans have a single native language compared to other ethnicities that have exposure to the English language. First-generation Korean American immigrants speak Korean almost exclusively in their homes and at work, while second-generation Korean Americans primarily speak English in their homes (Hurh & Kim,

1984; Min, 2000). Additionally, Korean Americans have churches and cultural institutions where they may continue to preserve and practice their cultural traditions and values. These institutions served as the foundation for preserving and maintaining traditional values, relationships with other Korean Americans, and fluency in the Korean language. Korean immigrants also have the opportunity to recreate a Korean community in the U.S. These groups were found to provide Korean immigrants an added psychological resiliency to deal with the transitional process of immigration. The Korean American church was founded in part out of a desperate need among the displaced Korean immigrants to befriend others of a similar background. These institutions and groups, e.g., church, temple, social groups, etc., are also an important vehicle in preserving Korean traditions, rituals, and values, and where hierarchical structures, filial piety, and deference towards authority are still intact and practiced (Hurh & Kim, 1990). Korean Americans can immerse themselves in such communities through these institutions and live without a pressing need to learn or adopt the mainstream culture. Still, Korean Americans are acculturating at varying speeds with many adopting only certain aspects of the mainstream culture. These values supplement their Korean identity rather than eliminating or modifying it (Hurh & Kim, 1988), which suggests that the enculturation levels remain the same even as acculturation increases.

Korean immigrant parents did not need to immerse themselves in the mainstream culture in order to operate a thriving business. In my personal communication with five Korean Americans (September, 2010), they reported that their parents worked all day to support their families. Three of the individuals' parents owned a small business, e.g. dry-cleaning and convenience stores, because it was possible for an immigrant like

themselves to sell goods or provide a service that did not require them to be fluent in English.

Acculturation and enculturation is partly suggested by language fluency. If a Korean American immigrant felt that being proficient in English was superfluous, then they may have a similar sentiment to embracing other aspects of the mainstream culture. Understandably, this can present a significant challenge for an immigrant who has lived much of their lives without the use of English. Korean immigrant parents, whose lives tend to be devoted to ensuring that their families are financial stable, may not find it that relevant to adapt to the mainstream culture and learn a new language. This process of acculturation may be seen more of as an inconvenience and an unnecessary burden.

The discrepancies in the rate of acculturation were pronounced between the Korean immigrant parent and the child, the latter of whom was found to experience more pressures to acculturate and to assimilate to their environment. In order for the immigrant child to be academically successful, he or she would need to internalize the values of being a good student, e.g., assertive, self-confident, explorative. And immigrant parents were found to encourage and push their child to assimilate to the mainstream culture. In a study by Kim and Wolpin (2008), Korean American parents strongly endorsed the integration of cultures of the indigenous and mainstream cultures for their children. The parents placed an expectation on their children to adopt the mainstream American values, customs, and traditions. On the other hand, the same parents did not have these expectations of themselves.

Without any incentive to adapt to the mainstream culture and embrace its values, some Korean immigrants are complacent living within their smaller Korean American

communities. On rare occasions, this type of individual may venture outside of his ingroup and experience the mainstream culture; however, such individuals may have little to no interest in assimilating into the Western culture or viewing American activities or ideologies, such as therapy or psychological health, as anything more than a means to pique their curiosity in the foreign and the other. Many of the Korean immigrants who came to the U.S. decades ago have maintained the traditional values from that time period; and despite the modernization of South Korea and the advent of more Western influences, such Korean Americans perceive the embrace of Western values not as being consistent with the evolution of Korean culture but as the partial loss of their ethnic identities. Kim (1993) posited that Korean immigrants are capable of trusting the U.S. and believing that they could participate in the mainstream society. However, to many Korean immigrants, being American does not present any conflicts in their cultural identities. Theirs is based on a pragmatic strategy of “accommodation without assimilation,” the selective internalization of the American culture. This is consistent with the findings of relatively high enculturation levels among Korean Americans. They have the freedom to decide which aspects of the mainstream culture they relate to and choose to embrace them. With regard to therapy, Korean Americans have disregarded the Western sensibilities of mental health and reacted to their outreach with detachment because it may not be consistent with their traditional Korean values.

Conflicts that arise from acculturation differences. Acculturative differences between family members could lead to misunderstandings and arguments. Such differences were found to place an additional strain and stress on the child, who was expected to live successfully in two different cultural worlds. Children had to know the

differences between engaging with their parents and with their non-Korean American peers and authority figures. Lorenzo (1995) conducted a cross cultural study in which he found that less acculturated Asian American children reported communication issues with their parents and were guarded from openly expressing their beliefs. They also described their parents as “not great listeners,” who were occasionally insulting and “not always believable.” The children in this study also reported being more withdrawn from their peers and participated in fewer social activities. Thus, they had fewer friends, on whom they could rely upon in times of need, and were not as interested in seeking help in times of trouble.

Korean American parents’ lofty expectations on their children were also found to precipitate arguments as a result of their differing interests. Kim and Ryu (2005) found that such parents frequently regarded their children’s “occupational successes” as the most important accomplishment in their own lives. Similarly, their children also regarded their “academic achievement” as the most important accomplishment they will have in their lives. Unsurprisingly, then, parents and their children both regarded the latter’s “academic failure” as the “most painful event” they can experience in their lives. These pressures to do well were more pronounced in recent immigrant families, as such achievements could potentially restore those parts of their parents’ self-esteems that were undervalued and disregarded upon immigrating to the U.S. These accolades were so important to the parents that they would sacrifice all of their personal comforts, social and economic statuses, and overall livelihood to immigrate to the U.S. for their family’s future successes. A child’s successes and failures defined the self-worth and self-esteem

of the entire family. There was an incredible pressure on the child to meet their parents' needs in the academic and career senses.

Conflicts between family members may arise from the discrepancies in their cultural beliefs, expectations, and norms. While acculturated Asian American adolescents were better adjusted to school and their communities, they reported more arguments and conflicts with their foreign-born parents, who adhered to tradition (Fu, 2002; Rick & Forward, 1992). Furuto and colleagues (1992) found that such relationships between parents and children of immigrant Asian families to be devoid of meaningful interactions.

In personal communication with two Korean American individuals (2011), it was reported that they resolved their conflicts with parents via compartmentalization. They were compliant in the presence of their parents. However, once they had reached an age where they made their own decisions, it became less important to solely follow their parents' desires and opinions (Leong, 1986; Root, 1985; Uba, 2003). Such children have to be aware of their traditional cultural values and aim to accommodate their parents to avoid otherwise inevitable tension and conflict with them.

Immigrant parents were not aware of the differences between Eastern and Western cultures. They chastised their child for being assertive, self-confident, and independent, not knowing that these attributes were adaptive in the school environment and characteristics of a successful student. These qualities may have been fostered in the school system and adaptively internalized by the child. The Korean American daughter may also have additional obligations from her parents to behave in accordance to the traditional gender roles.

Recent immigrants face the inevitable adjustments and transitions that arise from living in a foreign country. As with most immigrants, the majority of Korean immigrants have foregone various comforts and the familiarity of their home country. They immigrated with few supports accompanying them and, as the first of their family and friends to immigrate to the country. Much of their waking lives are spent working long and strenuous hours to support their families.

Psychological Disorders among Korean Americans in the United States

A breadth of studies (Abe & Zane, 1990; Cheng, Leong, & Geist, 1993; Crocker, Luhtanen, Blaine, & Broadnax, 1994; Flaskerud & Hu, 1992) has compared at the rates of psychopathology across ethnic groups and determined that the highest frequencies, durations, and severities of emotional distress were reported by Asian Americans. Local and regional community profile studies also indicated higher levels of psychological distress among the minority and American mainstream populations. The latter studies included a large sample of Korean Americans from highly populated areas and major cities, such as Orange County, CA (Kim-Goh, 2008) and New York, NY.

Compared to their White American counterparts, Korean Americans have significantly higher rates of psychopathology and emotional distress. These rates were found across many of the more common psychiatric diagnoses, such as Major Depressive Disorder, Anxiety Disorders, Alcohol and Substance Abuse/Dependence, and psychotic disorders. These findings suggested that the Korean American population has a frequency of mental illness that was comparable to other ethnic groups. Therefore, the low rates of mental health treatment utilization among Korean Americans were not attributed to their hearty psychological resilience to stress. The research literature has shown that without

the promise of financial stability and the stressors of adjusting to a foreign country, Korean immigrants report significantly higher levels of psychological distress.

Prevalence of psychological disorders among Korean Americans. Regional profile studies of Korean Americans were conducted between 2007 and 2009, in part to better understand the prevalence of mental health issues and the utilization rates of health care services among Korean Americans. According to Kim-Goh (2008), 11.6% of the Korean Americans in Orange County, CA were likely to have “psychological distress” based on the Kessler 6 scale; in comparison to the 2.9% of the overall sample, Korean Americans are experiencing psychological distress four times more frequently than the overall population. A similar discrepancy was found in a state-wide Health Interview survey across California, in which 8.6% of Korean Americans in California were likely to be experiencing “psychological distress,” compared to 3.8% of all Californians.

Levels of acculturation have been found to correlate negatively with psychological distress. In other words, Korean Americans with a lower level of acculturation were found to have more emotional distress and psychological problems. Elevated problems with self-image and self-esteem were shown among Korean Americans who were not fluent in speaking English.

One of the most frequent stressors reported by recent Korean immigrants has its origins in their limited capacity to communicate with Americans. Given the idealizations that Korean Americans tend to place on Western societies, and particularly the English language, not knowing how to speak it can lead to the feelings of incompetence, inferiority, and embarrassment. For many Korean Americans, the lack of fluency supports and confirms the notion of their powerlessness and strips them of a means to

express their thoughts, be understood, and engage in a social community. It is not uncommon for Korean Americans to be sensitive to the impressions of others, particularly English speaking Americans, and sensitive to the perceptions that they are “stupid.” On the other hand, English fluency is not only a means of assimilating and acculturating to America but of joining and feeling accepted by the majority.

Mood and anxiety disorders. Korean Americans endorsed more symptoms of Major Depressive Disorder (MDD) than several other Asian ethnic groups (Kuo, 1984). Korean American males were diagnosed with MDD considerably more often than their Japanese and Chinese American counterparts. Kim and colleagues (1998) also found that, among college student population, Korean American males obtained the highest scores on the Diagnostic Severity Ratings Scale and reported the most symptoms of MDD. Korean American females were also reported as having the most Affective Disorder symptoms of all the ethnic groups.

Asian Americans with higher levels of enculturation experienced a greater risk of psychological and emotional distress (Oh, Koeske, & Sales, 2002; Kim & Omizo, 2003). Approximately 24% of the Korean Americans sampled from a community based study in Orange County, CA reported feelings of depression and sadness on most days while approximately 10.8% from this sample reported high levels of stress on a daily basis. Some of the stressors reported in the study include: the process of adjusting to a new culture, with little to no social supports, long work hours (12 to 18 hours per day), financial instability, and concerns about failing and having to return back home to live with their families.

Korean Americans with higher levels of enculturation were found to have more problems overcoming and managing their stressors, which would manifest in affective symptoms. Several studies (Choi, 1997; Kuo & Tsai, 1986; Shin, 1994) have found that MDD is highly comorbid with significant levels of acculturative stress among Korean immigrants. Jang and Chiriboga (2005) also found that the lower acculturation levels among Korean American college students were associated with higher scores on assessments measuring depressive symptoms. In a similar study by Hovey and colleagues (2006), Korean American male college students reported relatively high levels of state and trait anxiety; the Korean American subgroup also obtained more depressive symptoms compared to the entire sample.

The dual and conflicting expectations from the family as well as the pressures of the environment experienced by Asian American immigrants, e.g. acculturative stress, have a significant impact on self-esteem and life satisfaction, and they are correlated with a higher frequency of psychosocial adjustment problems (Asakawa & Csikszentmihalyi, 1998; Florsheim, 1997; Gil, Vega, & Dimas, 1994; Padilla, Alvarez, & Lindholm, 1986). The Korean American children in these studies also presented with a poor sense of self and were apt to view themselves as unworthy, guilty, and shameful; they struggled to regulate their emotions and self-soothe in intensely pressured situations. Korean American children were also more likely to report a problem when it was in relation to issues with self-confidence, regulating their feelings of panic and stress in performance environments, and feeling a heightened sensitivity to criticism and judgment.

Alcohol abuse and dependency. Korean Americans have been connected to heavy alcoholic consumption, abuse, and dependency, which has been one of their largest

health concerns. The lifetime prevalence of alcohol abuse for Korean Americans is at 23%, the highest among East Asians, with rates of binge drinking four times greater than that of Chinese Americans (Wechsler, Dowdall, Maenner, Gledhill-Hoyt, & Lee, 1998). Kim-Goh (2005) found that Korean Americans have the highest percentage of alcohol consumption among Asian males at 63% and Asian females at 50.7% in California. There was also a significant discrepancy in the prevalence of binge drinking between Korean and Asian Americans within the past month with 15.8% and 9.3%, respectively. Alcohol use has self-medicating properties that can exacerbate or produce the onset of other mental ailments. Several studies (Duranceaux et al., 2008; Helzer et al., 1990) investigated the comorbid effects of alcohol abuse and dependency and discovered that a high frequency of depressive symptoms was more commonly found in Korean Americans who reported alcohol drinking.

Epidemiological studies on alcohol abuse and dependency have indicated that South Korea has one of the highest rates of alcohol consumption in the world. In 2003, about 64.3% of all South Koreans reported having at least one alcoholic beverage, a marked increase from the 48.3% of South Koreans in 1986. South Koreans consumed about 4.5 liters of distilled liquors in 2002, which ranked as the fourth highest alcohol-consuming country in the world after Russia, Latvia, and Romania (Chang, 2005).

Psychiatric disorders. A cross-national study by Jernewall and colleagues (2002) identified that 76% of Korean American youth who required emergency medical attention reported suicidality and “cultural conflicts with <their> parents.” Children who reported higher levels of intergenerational conflict and issues with their parents were found to have a 30-times greater risk of suicidality. According to a New York Times

article that examined three of major Korean funeral parlors in New York City, 31 Korean American residents of New York City reportedly committed suicide between January 1st and June 26th in 2009. This is more than two times greater than the regional average of 12 to 15 per year. Civic leaders cited money troubles and the extraordinary emphasis on academic and professional achievement as the leading causes for the high suicide rate.

Suicide was found to be the leading cause of death among South Koreans.

According to the World Health Organization (2009), 21.85 out of every 100,000 Koreans died by committing suicide, with males and females committing suicide at rates of 29.6 and 14.1 out of 100,000, respectively. This was more than a 50% increase from the previous year when it was determined that 13.8 per 100,000 Koreans died by committing suicide. According to a report by Statistics Korea ("Suicide leading cause," 2011), 15.3 per 100,000 Koreans between the ages of 15 and 24 committed suicide in 2009, the highest ratio among all causes of death reported for the age group. And suicide is considered to be the leading cause of death for South Koreans in their 20s and 30s as a result of the tight job market and greater economic pressures.

Of the thirty countries affiliated with the Organization for Economic Cooperation and Development, an association of wealthy, industrialized nations, South Korea had the highest rate of suicide at 28.4 per 100,000 Koreans in 2009. Male suicide rates in Korea rose from 12 per 100,000 Koreans in 1990 to 32 per 100,000 Koreans in 2006, while female suicide rates in Korea are among the highest among the list of countries, at 13 per 100,000. In a 2010 report from the Education Ministry, the fierce competition and pressures to succeed were the primary causes of suicide for three elementary school students, 53 junior high students, and 90 high school students.

Psychological disorders specific to Korean American females. Korean American females were found to possess a strong drive for thinness, dissatisfaction with physical appearance, and concerns with their body shape. A report from BBC News (Scanlon, 2005) indicated that more than 50% of Korean females in their 20s have undergone voluntary cosmetic surgery in 2010 and that more than 30% of Korean American females have voluntarily received cosmetic surgery.

Cosmetic surgery, in these circumstances, was described primarily as a means to enhance one's physical appearance and to bolster self-esteem. Chai (1998) interpreted this phenomenon of cosmetic enhancements as a means of self-improvement. In a male dominated culture, Korean females were more likely to experience themselves as subjugated and powerless in professional and social settings. Understanding that the Korean culture is one that places an importance on appearance and the perception of others, Korean American females may be motivated to enhance their physical beauty as a means of taking a hold of the power in their relationships.

Korean American females are believed to have a "prime age," in which the public will perceive their worth at the highest. A Korean American woman's self-worth and attractiveness falls precipitously from this point onward (Chai, 1998). As Korean American women approach middle age, they become more aware and self-conscious of how people treat them differently from a female who appears young (Song & Moon, 1998). Women striving for social, occupation, and economic upward mobility are likely to experience an increased pressure to conform to these ideal and norms (Hall, 1995; Mastria, 2002; Root, 1990) and may then seek to enhance their physical appearance through plastic surgery.

The definition of beauty has been characterized by distinctly Western features, e.g., the appearance of big eyes, a pale complexion, a sharp or pointed nose, and a small chin and mouth. It is no wonder then that Korean American females would most frequently alter their facial features particularly the eyelids, nose, and cheeks. Not unlike the Korean traditional values that encourage the perfectionistic pursuit of academics, beauty was also considered a practical goal towards enhancing one's self-worth and personhood that was made attainable through the advances in cosmetic surgery.

Institutional and systemic oppression towards females has decreased in the last 30 years in Korea, but this has paved a way for more subtle forms of gender inequalities and discrimination against women. Traditional Korean American families and older individuals are likely to adhere to an unequal division of responsibilities and rights between males and females. Following these social rules, an unemployed husband may expect his wife to cook dinner after coming home from her work. Such egregious power differences between genders have led to relatively high rates of domestic violence among Korean American couples.

Traditionally, Korean females are subjugated at every stage of their lives, which begins with their fathers until they are married, then to their husbands, and then to their sons. This means that men have the authority to physically discipline their wives. Song and Moon (1998) indicate that physically beating one's wife is acceptable if the wife provides the Korean husband's anger. Rhee (1997) found that Korean Americans reported the highest rates of domestic violence incidents in Los Angeles compared to all other East Asian ethnic groups. Respondents also indicated that the battered spouse is to blame in most situations.

A burgeoning job market and the financial demands of a dual-income household necessitate a new family role for many Korean American women, one that extends beyond their household responsibilities. This is a means of establishing greater economic flexibility, self-worth, and self-esteem among Korean American women. The husband may feel threatened and ultimately resort to physical violence, as a consequence of his wife's self-reliance and independence, in an effort to reclaim their authority and status within the household. Additionally, most wives are still expected to fulfill all of their household duties while they balance their career. It is not an uncommon expectation for the wife to take care of the home by themselves; though certain freedoms exist for Korean American women, theirs are still deeply entrenched in the traditional gender role demands.

Asian American Attitudes towards Psychological Services

The research literature has shown in the last three decades (Okazaki, 2000; Shin, 2010; Sue & Morishima, 1982; Uba, 1994; Yamashiro & Matsuoka, 1997) that Asian Americans have the lowest rates of mental health utilization. Asian Americans have been consistently viewed as the least likely of all ethnic groups to enter therapy. Cross-cultural studies have posited that attitudes towards help-seeking behaviors are influenced by acculturation to mainstream culture and enculturation to their traditions and values of the country of origin. This section aims to explore these interplays between traditional Asian values and the willingness to enter therapy and introduce the Asian American research literature on the obstacles and barriers to mental health treatment.

Help-seeking, enculturation, and acculturation variables. Several multicultural counseling research studies (Atkinson & Gim, 1989; Tata & Leong, 1994; Ying & Miller,

1992) examined how treatment fidelity and openness to treatment may change based on levels of acculturation and enculturation. Asian Americans who rated highly on the acculturation scale tended to express more positive attitudes towards seeking psychological services and also reported more help-seeking behaviors, e.g., willingness to seek out the assistance of others, therapy.

Conversely, adherence to traditional cultural values was inversely proportional to a positive attitude towards seeking mental health treatments (Kim & Omizo, 2003; Shea & Yeh, 2008), beyond the effects of stigma, gender, age, and relational interdependent self-construal. In order to be open to mental health treatments, one must believe that he can relate to the mainstream culture. Several studies (Baello & Mori, 2007; Kim, 2007) found that individuals with higher levels of enculturation had negative attitudes towards mental health services and more ethnocentric beliefs about the characteristics that define “good health.” These findings argued against previously held beliefs about the relationship between acculturation and help-seeking attitudes.

A study by D. W. Sue (1994) found that more highly enculturated Asian Americans expressed that they would have felt embarrassed and concerned on behalf of themselves and family if the general public would have been aware of their personal problems. There was no point in talking about oneself to another person. Disclosing personal matters outside of the family was then perceived to be self-destructive and unhelpful among Asian Americans. On the other hand, acculturated Asian Americans were found to have a greater English fluency and higher levels of education, a combination that positively correlated with a greater likelihood of utilizing and benefiting from mental health services.

Barriers to treatment among Asian Americans. The multicultural research literature (Aylesworth, Ossorio, & Osaki, 1980; Campinha-Bacote, 1997; Keh-Ming, Inui, Kleinman, & Womack, 1982; Levek, 1991; Nah, 1993; S. Sue, & McKinney, 1975, 1980) has identified a long list of barriers to mental health treatment services. The perceptions of mental health, emotional responses to mental illness, and the cultural differences that presented as barriers were documented. Leong and Lau (2001) compiled a comprehensive list of treatment barriers and five domains in which the former were grouped: cognitive, affective, value orientation, physical, and specific barriers.

Cognitive barriers. The nature of a “mental illness” is socially constructed and shaped by the popular understanding of what constitutes “normal” and “pathological” behavior. What one population perceives as “abnormal” or “deficient” may be viewed by another group of people as “healthy” and “appropriate.” This presents the question of how mental health is defined by Korean Americans. Korean American males in two separate studies by Hurh and Kim (1988; 1990) defined “positive mental health” by a group of work-related factors, such as income, job satisfaction, and occupation. Their female counterparts commonly associated “positive mental health” to family life satisfaction and ethnic attachment variables, such as relationships with other Korean Americans, their participation and standing in the Korean American church, and Americanization variables, e.g., acquiring their driver’s licenses, learning English, and having non-Korean American friends.

Asian perspectives of health, ill health, and health care are informed by the precepts and principles of Confucianism, which is evidenced by the importance of the integration and interrelationship of the mind and body. A decline in mental health is

understood by its constellation of physical symptoms throughout the body. For instance, physical discomfort was commonly reported by Asian Americans in combination with emotional and psychological distress (Uba, 1994). A depressive mood was found to manifest by a physical sickness or a lack of motivation on the part of the afflicted (Kleinman & Good, 1985). Somatization symptoms, such as insomnia, headaches, poor appetite, and lethargy, were signs of an anxiety or mood disorder or an adjustment disorder with anxious or depressed mood (Gaw, 1993). Kim-Goh (2008) also found that some Korean Americans believed that depressive feelings were a normal part of everyday life for everyone and must be controlled and managed by self-will. All of these symptoms were understood as physical problems and, from the Asian perspective, all of their treatments were unsurprisingly approached from this framework, as well.

Asian Americans were found to seek medical doctors and alternative medicine practitioners, e.g. acupuncturists, herbalists, and church leaders, in times of mental distress. If an Asian American suffered from depression, he would be encouraged to live out a more active lifestyle despite his body's sluggishness and disinterest in the world. One study (Akutsu, Castillo, & Snowden, 2007) found that Asian American families would seek out mental health treatment services only after they were no longer able to tolerate the member's symptoms. In a separate study by Gim, Atkinson, and Whiteley (1990), college counseling centers indicated that Asian American students were more likely to seek psychological services due to academic, financial, and future career-related troubles. Contrastingly, this study also indicated that Asian Americans were significantly less likely to enter treatment due to insomnia, substance abuse, roommate issues, and identity confusion compared to students of other ethnic groups.

How do Asian Americans conceptualize a psychological illness? One Asian American sample stated that a “mental health issue” is defined by a set of behaviors that disrupt the harmony of the social group (Tracey, Leong, & Glidden, 1986). Thus, an individual who was mourning the loss of a loved one would appropriately express his or her emotions in private. The public display of emotional distress would be viewed as a “mental health issue” if it involved others, as this gesture may be perceived as an inability to manage oneself and one’s own emotions. Moreover, the listener may then internalize these pains, which can be emotionally taxing. The message conveyed here is that individuals should not talk to anyone about their problems as the very act of sharing will ultimately cause more problems onto oneself and those listening.

Affective barriers. In the past decade, psychological research has doubled its efforts to understand the significance of affective and emotional associations to mental health. A study by Shea and Yeh (2008) found that a higher level of perceived stigma towards receiving psychological help was correlated with a negative attitude towards help-seeking behaviors. Stigma towards psychological treatments stemmed from cultural differences between counseling and the methods of dealing with psychological problems among traditional Asian communities. Receiving psychological help may be perceived as a sign of weakness (Narikiyo & Kameoka, 1992), personal immaturity (Uba, 1994), or an indicator of a genetic flaw (Flaskerud & Liu, 1990; Yeh, 2000), all of which may warrant shame upon the family.

In personal communication with an Asian American college student (2010), he noted that relying on a professional to “manage his life” represented a “failure” on his part to be self-disciplined and to “endure and come out successful in facing the

challenges of life.” Asian Americans strived to be independent and capable of managing their own lives. The process of discussing problems with a psychologist may imply inadequacies in family support, and this may bring shame and disgrace to the family (Zane & Yeh, 2002). This finding is consistent with earlier studies (Kleinmann & Lin, 1981; Uba, 1994), which found that when Asian Americans entered therapy, it was accompanied with feelings of shame and embarrassment.

Lin, Tardiff, Donetz, and Goretsky (1978) found that Schizophrenic children of Asian American families were confined to their homes. Such families were highly invested in keeping their child from the public, even if it meant that they had to tolerate the discomfort and pains of taking care of a needy, severely mentally ill child. Lin and colleagues (1982) noted that Asian American parents showed longer delays in seeking professional services for treatment; and that their eventual motivation to find help for their child was primarily out of their own sense of responsibility and culpability.

The origins of this shame may be explained by the Confucian concept of filial piety, which states that no person should bring dishonor to the family (Sung, 1992). In collectivistic and group-centered societies, any behavior that reflected a lack of self-discipline, self-control, and respect for rules could be perceived as a disgrace onto the entire family (Webster & Fretz, 1978). Mental illness was not simply perceived as a personal matter of the affected individual but as a threat to the “homeostasis” and “harmony” of the entire family (Lin & Cheung, 1999; Okazaki, 2000). Seeking help outside of the family was thus viewed as a weakness within Asian American communities (Root, 1993). Similarly, Korean Americans were found to share a commonly held belief that mental illnesses emanate from family wrong-doings (Uba,

1994), and are thus preventable assuming the family is in good and healthy standing. As such, the public acknowledgement of a mental ailment was representative of the entire family and reflected their collective inability to take care of an inflicted loved one.

Value orientation barriers. Multicultural researchers have examined the impact that certain cultural variables have had on an individual's willingness to enter therapy. What these researchers (Kim, Yang, Atkinson, Wolfe, & Hong, 2001; Kim, Atkinson, & Yang, 1999; D. W. Sue & Sue, 1999; Atkinson & Gim, 1989; Tata & Leong, 1994; Sue, 1977; Kim & Omizo, 2003) identified were nine unique characteristics that comprises the Asian value system: emotional self-control; conformity to norms; avoidance of family shame; collectivism; deference to authority; family recognition through achievement; filial piety; hierarchical relationships; and humility. A study by Shea and Yeh (2008) supported the notion that each of these values contributed to negative help seeking attitudes among Asian American college students. Unacculturated Asian Americans, particularly those who demonstrated a greater emotional self-control and conformity to norms, expressed more negative attitudes toward therapy and were less interested in meeting with a mental health professional than their acculturated counterparts. Among those who chose not to express their thoughts or feelings freely, therapy was less helpful as it requires a willingness and ability to communicate one's problems to another person.

In my personal communication with four male, Korean American college students, the notion of sharing one's problems with another person went against their natural proclivities to take care of the problem on their own. It was an embarrassing and shaming admission of their weaknesses; and doubly burdensome to share their stories, as it now made them responsible for how it may negatively affect the listener. Talking about

such problems was thought to unnecessarily “expose” additional issues and complicate things further. Thus, the method of choice was to hold onto one’s “problems” and allow time to “will them away.”

Their conceptualization of mental health was determined by how it interfered with the harmony of the individual’s relationships among family and friends. Thus, feeling sad and hopeless and being physically exhausted consistently for more than one month were not sufficient to acknowledge the presence of a psychological issue. More traditional Asian Americans would define a psychological issue as something that impairs their ability to control and manage their behavior.

Physical barriers. Some individuals do not participate in therapy due to a lack of physical resources. This includes being knowledgeable about the benefits of therapy and where it is offered, or knowing where to obtain this information. Obviously, those who do not know anything about therapy will not know where to seek it. Other physical resources include a means of transportation, availability, money, and insurance.

Though mental health services are available at a discount and covered by government funded programs such as Medicaid and Medicare, knowing how and where to obtain this information requires a level of resourcefulness that can be challenging for recent immigrants. Utilizing an alternative means of transportation, like the bus, train, and subway systems, requires an understanding of the intricacies of complex system. Understandably, persons who do not have time to invest in learning these systems are not likely to utilize therapy, let alone know where to obtain it. Navigating these programs can be complicated and difficult, and they may not be easily accessible especially for those who are not proficient in English.

Among the 330 Korean American residents of Orange County surveyed, 27.7% did not have health insurance, more than three times that of any other East Asian group and five times that compared to non-Latino Whites. Additionally, more than 1/3 of the Korean American sample was “linguistically isolated” and lacked proficiency with the English language. Their poverty rate was greater than county average (10.6% vs. 6.6%) and more than one quarter of the families received governmental assistance. Of greatest concern among the Korean Americans in this study was the lack of knowledge regarding existing health resources, with 22.3% of the sample reporting that they had no regular doctor to visit when they were sick or in need of health advice. 18.9% of the Korean Americans in this study were self-employed, suggesting that a large proportion of Korean Americans worked long hours, paid, if at all, for their own health insurance, and had no regular physical activity (52.9% vs. 75% of the entire county). Orange County, CA contains the second largest Korean American population in the U.S., with more than 82,000 residents. This should be an indication of the limitations that recent Korean American immigrants encounter.

A community profile study in New York City, NY, found that Korean Americans had an average household income (\$37,094 vs. \$38,293), median family income (\$39,144 vs. \$41,887), and per capita income (\$19,094 vs. \$22,402), all of which were under the regional average. This suggested that the financial commitments to meeting with a psychologist on a weekly basis seemed to be above their financial means. More than 40% of this sample was not fluent in English, which was significantly higher than the 13% average. Lastly, about one in four elderly Korean Americans was classified as living in poverty.

Korean American Mental Health

Overview of Korean American attitudes towards psychological services. A disproportionately low proportion of Korean Americans was found to participate in mental health treatment services. Two studies (Jang, Chiriboga, & Okazaki, 2009; Lee et al., 2004) have indicated that these rates of underutilization were primarily due to the discrepancies between traditional Korean and Western American cultures in communication styles and help-seeking behaviors. Kim (2005) suggested that the rates of psychopathology among Korean Americans could be underrepresented because many Korean Americans found it easier to avoid their problems and its associated feelings of shame and guilt.

Several studies (Leong, 1986; Sue & McKinney, 1975) also found that Korean Americans were reluctant to seek help even after they had acknowledged having a psychological problem. This was also apparent in a community study by Kim-Goh (2007), which found that among the 11.6% of the Korean American residents of Orange County, CA, who reported psychological symptoms only 1.7% sought out any kind of therapy from a mental health practitioner. These phenomena are consistent with the hypothesis that higher levels of enculturation contribute to the reluctance and unwillingness to utilize mental health treatment services.

Korean Americans were found to be highly invested in maintaining a positive impression in the public eye. In part Confucianism, Korean Americans were known to actively establish peaceful relations with others and inter-harmony within their social groups. They were extra vigilant to conceal the ailing family member's mental illness and prevent it from manifesting in the presence of others, even if it meant that family

members would lie or not tell the truth. Korean American parents expressed that they were culpable for their child's psychiatric diagnosis, reasoning that their poor parenting skills and their inability to help their child to manage his or her academic demands caused the illness (Donnelly, 2005).

A New York Times article (McDonald, 2011) discussed the "taboo" of sharing emotional problems with another person and how these concerns were preventing and discouraging South Koreans from entering therapy today. In the article, Dr. Kim Hyong-soo, a psychologist and professor at Chosun University at Kwangju, posited that the majority of South Koreans have the impression that they will be stigmatized for the rest of their lives if they meet with a psychologist. Some South Koreans, however, equated meeting with a psychologist to talking with a friend or receiving support from a pastor. The article also quoted a preeminent psychologist, Dr. Park Jin-seng, who stated that in his practice talking therapy is more amenable to highly educated South Koreans who were more familiar with the "Western ways."

In my personal communication (2008) with a group of Korean American college students, they shared their ambivalence towards therapy. On one hand, they expressed an appreciation for therapy and an understanding of its undeniable efficacy with some individuals. Should a friend ever be in need of professional support and emotional counseling, there seemed to be no doubt in their minds that they would strongly encourage this friend to participate in therapy, even if they had to find the therapist and schedule the first appointment. Interestingly, this therapy-friendly attitude did not extend to their personal lives as reflected by a crippling ambivalence. While they admitted to having problem in the past that could have been addressed in therapy, they could not find

a reason, convincing enough, to enter therapy on their own volition. The uncertainties of therapy intensified their reluctance to “let go” and take stock in the possibility that it could help them. It was apparent how uncomfortable they felt about the idea of entering therapy. Other students were less diplomatic and expressed that therapy would not be helpful to them as most psychologists were “old, white males, who were too fixed in their ways” to relate to their experiences or perspectives in any meaningful way. These sentiments engendered a skepticism and distrust towards therapy. Kim (2005) posited that such misconceptions and misinformation about therapy were related to their cultural lens.

Religious institutions were found to conceptualize their members concerns from a spiritual lens and to provide treatment that was rooted in their spiritual faith. Kim-Goh (1993) found that Korean American clergymen considered symptoms of psychosis with religious delusions a spiritual phenomenon, and one that should be resolved through prayer and religious involvement. Considering more than 70% of Korean Americans have participated in church at some point in their lives, the message of the church has a considerable potential for impacting the perspectives from which a Korean American defines and approaches mental health.

Several studies (Dearman, 1982; Hurh & Kim, 1984) found that Korean Americans relied heavily upon their church communities for social, emotional, and spiritual support. In particular, pastors and clergy members were found to serve as the initial contact when someone from the congregation placed a request for social support (Leong, 1986). Korean American elderly identified their fellow church members as emotional supports, in addition to their kin, friends, and neighbors (Kim, 1999). Churches have been one of the most significant institutions in the Korean American community.

Indigenous cultural values. Traditional Korean values have been found to promote a style of relating that subsequently impacts how mental health is viewed and understood by Korean Americans. In a study by Kim (1992), three indigenous values, e.g., *jeong*, *haan*, and *noon-chi*, were identified as the most relevant concepts in defining the relationship with Korean in therapy. While the scope of this paper aims to enhance the therapist's cultural competence in working with Koreans, its concepts may be applied to understanding the contrasting styles of communication and the multitude of levels in relating

Jeong. Among traditional Koreans, interpersonal relationships revolve around the word, *jeong*, which consists of the following characteristics: affection, love, sentimentality, sympathy, and connection. Kim and Ryu (2005) characterized *jeong* as an interpersonal quality that “enriches and humanizes all social relationships and makes life more meaningful.” *Jeong* is the type of bond that allows an individual to unconditionally embrace and commit to the other without validation, logic, or reason.

Relationships with *jeong* are deeper and longer lasting. More than kindness or a liking, *jeong* brings about the “special” feelings in relationships: togetherness, sharing, and bonding. *Jeong* is what makes one say “we” rather than “I,” “ours” rather than “mine” (U. Kim, 1994). The imagery of *jeong* is a quiet, gentle, nurturing, caring, giving, trusting, loyal, considerate, devoted, dependable, and sacrificial (Kim, Kim, & Kelly, 2006), in which the emphasis is on meeting the other's needs. Ultimately, *jeong* represents a deep-long lasting friendship. As such, questions like, “How are you?” convey a deeper inquiry of concern and care for the other's health, similar to a question like, “Are you at ease?” *Jeong* is best described by its features. In the table below (Kim,

1996) details the important distinctions between jeong and a comparable quality in Western societies, love.

As described by the table on page 162, jeong is a complex bond between individuals that develops naturally as trust is slowly established over the course of the relationship. Jeong places an emphasis on loyalty to the other over personal wants and needs. Compared to its Western equivalent, love, jeong may manifest in inter-dependency or, in some cases, a passive-dependency in the other.

Haan. *Haan* has multiple layers of meaning, and it may be best understood as the cultural expectations for expressing negative emotions particularly anger and frustration. According to Kim et al. (2006), *Haan* refers to “suppressed anger, unexpressed grievance, resentment, indignation, despair, or holding a grudge.” Traditional Korean precepts have discouraged the overt expressions of anger. When anger is suppressed, it accumulates over time and eventually transforms into feelings of *haan*. Kim (1996) described the positive consequence of *haan* as that which “creates and sustains strong motivation to persevere and fight until justice is achieved.” *Haan* is manifested in the Korean’s endurance and persistence in times of hardship, determination, and heroic deeds.

Noon-chi. Kim (2006) refers to *noon-chi* as one’s “intuitive capacity to size up and evaluate another person or social situation quickly.” Implicit in this assessment is a heightened sensitivity to nonverbal cues, such as facial expressions, voice intonations, and body language. Compared to Western cultures, in which clear, direct, and explicit communication is highly valued, *noon-chi* indicates that communication is “less clear, indirect, implicit, and often nonverbal” (Kim, 2006). An individual who lacks *noon-chi* is considered “insensitive, uncouth, unmannered, and uncultured” (Kim, 2006). This style

of communication is diametrically opposed to the style that is necessary in order for an individual to yield any gains from therapy.

Traditional concepts of mental illness and folk healing practices. Traditional Korean belief systems characterize “mental illness” as the following: 1) a manifestation of an affliction caused by evil and vengeful spirits; 2) a reflection of an intrinsic weakness; or 3) an imbalance in the individual’s energy system, also referred to as the yin and yang. Individuals experiencing such phenomena may then be described as “crazy,” “mad,” or “abnormal,” all of which convey a person whose behaviors are impulsive and dangerously unpredictable. The Korean society considers mental ailments to be an infectious disease with its carrier deserving of isolation from the greater society. With such negative connotations to the western sensibility of mental health, the reluctance Korean Americans have towards therapy may be explained by these indigenous understandings. Is it possible then that Korean Americans are more likely to seek comfort and resolve their mental illness through indigenous treatment interventions? This section will describe the three traditional ideologies, e.g., shamanism, Chinese medicine, and Taoism/Buddhism, through which Koreans conceptualize mental illness.

Shamanism. Shamanism is rooted in an ancient belief in a world inhabited by spirits. The shaman has been known as a “magician, medicine man, psychopomp, mystic, and poet,” whose capacities to access the spiritual realm differentiates them from any other healer or priest. This is the world which the shaman’s soul enters in order to engage with the helpful and evil spirits. The prospective shaman often becomes one reluctantly through a painstaking process that involves a series of severe physical and mental afflictions. This process involves the experience of self-loss, a loss of appetite, insomnia,

and visual and auditory hallucinations. This condition is an illness known as *Shinbyeong*, which can manifest differently depending on the individual's background and last a surprisingly long time. Eventually, all individuals have an experience that which psychiatry has labeled a hallucination, which is considered progress and the entry to the final ritual where the shaman receives her spirit and accepts her calling.

Shamanism posits that all objects are endowed with spirits and that human misfortune, e.g. psychological, physical, or spiritual dimensions, is a product of an improper relationship with these spirits. A shaman is a qualified mediator between the spirits and the afflicted individual; the shaman guides the individual in a ceremonial ritual that is intended to restore a sense of harmony among the spirits. These rituals range from the simplest forms to the most elaborate form, *gut*, which can take upwards of 24 total hours over the span of several days. There are more than 20 identified rituals that are linked to a particular event, such as death, or the lunar calendar. These ceremonies initially involve dancing, jumping, and drum-beating; and involves the shaman delivers an oracle in a gesture to invoke the shamanistic gods who would mediate, forgive, and empower the patient.

Shamanism purports to relieve individuals of phenomenon that is considered a mental health disorder. Several researchers (Kim, 1982) investigated the effectiveness of this form of healing and found that it was marginally and temporarily helpful at best. Of 17 patients, four with a diagnosis of an anxiety disorder and one with a diagnosis of schizophrenia, six became more disturbed following the ceremonies. Another researcher (Rhi, 1970) reported that rural people who had been treated with shamanistic ceremonies responded favorably in 38% of the cases, unfavorably in 8.7%, and remained unchanged

in 52%. Thus, while it may be possible that Korean Americans seek out shamans and the support of other indigenous services, the mental health symptoms are likely to persist.

Chinese medicine. Traditional Chinese medicine has had an influence in Korea for many centuries. It is understood that humankind is viewed as a microcosm of the larger universe, in which the flow of the cosmos affects the inner workings of the body. In other words, health depends on the proper adjustment of the body to the environment and a harmonious relationship between bodily functions and emotion. The heart is the reservoir of pleasure and spirit; the liver is the seat of anger, courage, and the soul; the gall bladder is the locus of decision making and power; the spleen is the center of idea and will; and the kidneys give rise to fear. Depressive symptoms are then interpreted as an imbalance in the liver and kidneys. Persisting symptoms of mental illness are perceived as a hereditary weakness, character weakness, and a physical or emotional strain.

The traditional Korean's view of health and beliefs are rooted in balance of Chi energy. The negative symptoms of schizophrenia, such as withdrawal tendencies or a decreased level of motivation, were perceived as an imbalance or lack of Chi. Immigrant Korean parents sought help from an Oriental doctor, who provided a special tonic that restored the Chi energy, and from an acupuncturist, who balanced the Chi energy.

Buddhism and Taoism. Confucianism and Taoism remain strong influences on how Korean communities interpret mental illness. Taoism first entered Korea during the period of the Three Kingdoms (300 to 668). Due to the presence of Buddhism and Confucianism, Taoism never gained much recognition outside of the meager support it received from the government during this time; however, its principles were

unsurprisingly infused into the mainstream Korean culture, which are present today in the negative perceptions and stigmas of mental illness. Taoism regards health to arise from a balance of life. As such, a mental disorder is then rooted in an excessive striving towards something, an imbalance, and a lack of peace in the mind. It is no wonder that traditional Koreans believe that mental illnesses are controllable and manageable; and thus, associated with immaturity and a weakness, especially when a professional is consulted for support.

Buddhism has flourished in Korea for many centuries and its principles have asserted a considerable influence on the perception of mental illness. Buddhism embraces the view that life comprises suffering and that the end goal of this suffering is the path to enlightenment in the next life. As such, life, in the worldly sense, is not something that is controlled but embraced. Then, one's suffering is to be accepted and one's hardships faced with a persevering and enduring spirit. Mental illnesses may then be viewed as a burden that is managed privately. Professional services and mental health treatments seem superfluous and unnecessary.

Statement of the Problem

As supported by the research literature (Cheung & Snowden; Kinzie & Tseng, 1978; Snowden & Cheung, 1990), a disproportionately low number of Asian and Korean Americans have been involved in therapy despite the comparatively high prevalence of psychological distress and psychiatric symptoms. Several community profiles (Kim-Goh, 2008) in areas densely populated with Korean Americans found a large discrepancy in the number of Korean Americans suffering from stress that compromised their daily functioning and the number of Korean Americans seeking and receiving psychological

support. According to Kim (2005), Korean American utilization rates of mental health services were amongst the lowest in the U.S.

The cross cultural research with Asian Americans (Kim & Abreu, 2001; Kim, Atkinson, & Yang, 1999) has indicated that this discrepancy may be attributed to the differences between more individualistic (U.S.) and collectivistic (East Asian) societies in their understanding of mental health. Culturally based values, norms, and perceptions inform the way in which an individual defines “mental illness,” “mental health,” and the mechanisms of positive change. Contrary to western practices, sharing personal problems or seeking support outside of the family to address them were viewed negatively and perceived as counterproductive. One’s culture informed the way an individual saw himself as he struggled to overcome his psychological distress or the way an individual viewed a family member, friend, or a peer who was in a similar state. Within collectivistic societies, one’s public persona and impressions were highly important and necessary to maintain to have social standing.

The opinions and perceptions of others were strongly considered when one was making a life decision, particularly if the outcome of such decision was suggestive of a personal weakness or deficiency. A traditional Asian American may be more sensitive to the criticisms of his family, friends, and community and, therefore, more likely to feel shame and embarrassment for entering therapy. And because therapy is still an unfamiliar form of treatment among many Korean Americans, it would be harder to know where to begin their process. The lack of physical resources, such as time, money, mode of transportation, and awareness of therapy, were common obstacles to therapy. There are a multitude of cultural barriers to mental health treatment. Despite all of the evidence that

proclaims the benefits of therapy, the majority of Korean Americans who have psychological needs choose not to participate.

Efforts in outreaching to Korean Americans in academic and community settings have been moderately successful at best. There was compelling evidence that the mental health services in academic settings were not adequately equipped to handle the care of Asian Americans. This was partly due to the reality that the majority of the Asian Americans who entered therapy were severely impaired, which required a level of care that the college counseling centers were not equipped to handle (Snowden & Cheung, 1990). Treating such students also required more time and experienced clinicians, which was taxing to the faculty of staff psychologists. Secondly, while training institutions profess the teaching of cultural competency, a study by Boysen and Vogel (2008) indicated from their sample of White American psychology trainees that implicit racial biases (aversive racism) were unaffected.

The psychological literature has greatly emphasized the development of culturally sensitive interventions for ethnic minorities, perhaps at the cost of understanding how individuals of such populations enter therapy. While this is an understandably important endeavor, the ultimate success of these interventions is measured by its overall impact – the number of ethnic minorities who receive such forms of treatment. The aim of this study was to understand the underlying processes of entering therapy from the perspectives of one ethnic minority group, Korean Americans.

This study examined how some Korean Americans make the decision to participate in therapy. There was a wide range of openness to therapy among the participants. There was a participant who simply referenced the Yellow Pages and

gathered a list of potential psychologists because they needed to talk to someone; and others who had to think through the ramifications of entering therapy, identifying and weighing the pros and cons and figuring out what was best for them in that moment before deciding to research the psychologists they wanted to meet. For the majority of the participants, this process lies somewhere in between these poles.

In developing a clearer understanding of the factors that motivate Korean Americans to pursue therapy, the field of psychology can learn how individuals from some of the more difficult to reach immigrant communities become interested in mental health. As the research literature becomes more familiar with these narratives, clinicians can work towards identifying more effective methods of mental health outreach to Korean Americans as well as other immigrant populations.

The findings from this study highlight the intricacies of the Korean culture and examine the processes underlying the ambivalence towards therapy. Mental health clinicians familiar with this process may have an understanding to express a deeper empathy towards their clients of Korean descent particularly those who entered therapy unsure and skeptical of how it can be helpful. As this is the first study of its kind, very little information seemed to be available in the psychological literature. The importance of gathering the participants' narratives was therefore that much more important.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Rationale for Research Design

This research study was qualitative and phenomenological, and it was aimed at raising the awareness of the Korean American processes involved in entering therapy. A requisite of the phenomenological inquiry is the suspension of the interviewer's preconceived beliefs. A conscious effort was made on the part of the interviewer to avoid asking the participant any questions that may be suggestive or leading. Instead, a curious inquiry is drawn from what the participant initially provides during the interview. The rationale for implementing this type of research was to generate ideas and an understanding from the participants' narratives.

The lack of research on this subject matter suggested to this writer that an important step in gaining an understanding of the processes in entering therapy is to ask Korean Americans who have had that experience directly. The limited research with Asian Americans was a guideline for the themes that were discussed throughout the interview. In order to avoid the field of psychological research from imposing or prematurely interpreting the experience of individuals from a culture whose values are different from mainstream Americans, and other immigrant cultures for that matter, is to provide an opportunity for their voices to be heard and represented. In doing so, we may be able to arrive at a clearer understanding of the considerations that some Korean Americans make in deciding whether to enter therapy.

As a Korean American graduate student of clinical psychology and participant in therapy, I am aware that my perspectives about therapy are shaped by my own

experiences. This lens can impact the way I sit down with the participants for interviews, in that I can impose my own views throughout the interview and influence the response of the participant. In this regard, I aimed to be as mindful as possible of my subjectivity.

Research Design: Grounded Theory Approach

The Grounded Theory (Glaser & Strauss, 1967; Glaser, 1992) approach to research was originally devised to facilitate theory construction. Growing out of a discomfort with the supremacy of theory testing between the 1940s and 1960s, Glaser wrote in the *Discovery of Grounded Theory* (1967) that the training of graduate students focused on confirming the ideas of early theorists. The one-sidedness prevented the flow of ideas and a “failure to appreciate the complexity and diversity of social life” (LaRossa, 2005). This led Glaser and Strauss to design a set of concrete set of rigorous research procedures that was accessible to novice and expert researcher alike.

Unlike traditional scientific research, which has a defined research question that is tested, the Grounded Theory process begins with a general research topic. In other words, there is no predetermined research “problem.” This is the “preparation” stage. A set of topics defined as the “substantive area” then guides the researcher in the process of data collection. The most common form of collecting data is the intensive interview, which can be combined with a form of quantitative data such as participant observation or a measure. It is an open-ended process. During the interview, the participant is not supposed to feel forced or guided into an idea, concern, or jargon by the interviewer.

The data is then analyzed using a variety of coding procedures. The analytic process is to identify general categories and properties based on the content in the participants’ narratives. Analysis begins with open coding, which is described as a

procedure where “the data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena reflected in the data” (Strauss & Corbin, 1990). In this phase, the researcher is interested in identifying, naming, categorizing, and describing phenomena found in the data. The next step in the analysis is known as axial coding, which emphasizes the causal relationships between categories, and strives to fit these categories into a basic framework that comprises the phenomenon, causal conditions, context, intervening conditions, action strategies, and consequences. The last phase, known as selective coding, is the process of identifying a core category that is able to capture the overarching theme. Strauss and Corbin describe it as a variable that has “analytic power” because of its ability to pull the other categories together to form an explanatory whole (LaRossa, 2005).

The Grounded Theory is an inductive process in which categories are extracted from the data and used to form a hypothesis on the research topic. The identified themes are then referenced to the extant research literature, of which its findings are incorporated in the literature review. It is a recursive process. As each interview data is collected and analyzed, the research literature is then tapped for any relevant information. In conducting ground theory research on this population, the researcher has to consider the surrounding world, that is, the reality in which these people choose and ultimately decide to enter therapy.

Research Participant Selection

After receiving approval from the Institutional Review Board, participants were recruited through three different channels: 1) grassroots marketing through Korean

American organizations, e.g. church and college groups, convenience stores; 2) through the assistance of friends and acquaintances of this researcher, who recruited their Korean American relatives and friends. Korean Americans constituted by this study are individuals of Korean ancestry who have been settled in the U.S. for 6 months. Korean immigrants (e.g. 1st generation) and ethnic Koreans born or raised in the U.S. (e.g. 1.5 to 2nd generation) will collectively be referred to as Korean Americans in this paper.

Study participants are required to be of Korean ancestry, at least 18-years old, and fluent in the English language. Moreover, such Korean Americans are required to have a series of at least three voluntary professional contacts with a mental health practitioner in the U.S. As such, any mandated treatments called upon by the court of law or any professional consultation in the psychiatric emergency room does not meet the criteria for our study. Lastly, individuals with professional affiliations with the mental health industry, e.g. psychiatry, clinical psychology, social work, nursing, or counseling, or those who have personal relations with the researcher will be excluded from this study.

Ethical Considerations: Protection of Human Subjects

This study recognized the sensitive nature of the discussion topics as well as the reluctance and reticence that Korean Americans, in particular, have towards sharing personal information to someone they do not know. This study recognizes and acknowledges the potential risks of recalling and reflecting on the life events that lead someone to enter therapy. They can be emotionally charged, and talking about them may evoke distressing feelings. As such, participants are offered the option to decline a question and withdraw from the study if they are unable to continue. Participants are also encouraged to contact the researcher in the event that they experience distress following

the interview. In another measure to ensure safety and support, participants were debriefed at the end of the interview and provided the space to share their reflections if they wanted to. As such, participants were informed of their rights as a participant of the study and the potential, though improbable, risks in being a part of the study.

Participants were required to sign an informed consent (Appendix B) before they may take part in the study. This form details the purpose and procedures of the study as well as the benefits and risks of participating. The participant's confidentiality and the protocol for handling and disposing of the data and sensitive materials are also discussed. For their reference, each of the participants was given a copy of the informed consent form after the interview.

The nature of the recruitment (grassroots marketing) entailed that there were two or more degrees of separation between this researcher and the participant. In other words, there were several instances in which the researcher and participants both have a relationship with the same person. Because the Korean American communities in New Jersey and New York are closely-knit, it was not uncommon for the researcher to cross paths with a participant. In regards to the participants' confidentiality, this may understandably heighten any concerns that may be present regarding the confidentiality of the information that is provided throughout the study. To this end, participants were assured that their information will not be used outside of their study and that all hard and digital copies of the interview will be destroyed.

Confidentiality. All physical and digital copies of the interviews were handled with strict regulations. A digital audio recorder and a telephone conversation recording microphone were used to capture the entirety of the interview on a digital mp3 file. Each

recording file was securely protected with a password and saved on a password locked computer. Upon transcribing the interview, the files were deleted from the recorder. All of the hard data, e.g. transcriptions and forms, withheld the names of the participant and his or her family members, friends, and extended relatives; and all of the interview data has been de-identified. And finally, upon completing the research, all recordings, transcriptions, and hard copy records were shredded and/or destroyed while all audio and computer files were deleted.

One undergraduate research assistant from Rutgers University helped in transcribing two of the interviews. As a requisite of this study, the research assistant was taught 1) the procedures for how to transcribe the interviews, 2) how to handle the hard and digital copies of the interview, and 3) how to maintain the confidentiality of the participants. This training protocol was extremely important as the research assistant knows of the participants in the study.

Data Collection

This study aimed to examine the context and experiences that precede Korean Americans' involvement in a mental health service. In an in-depth interview, subjects were asked to talk about the issues that the Asian American population is likely to encounter. Data collection took place over one to three periods, depending on the availability and preference of the participant. Some individuals were comfortable sitting and talking for upwards of 120 minutes in one session; whereas, other individuals needed to divide the interview into two or three 45-minute sessions. Additionally, some participants had more to say than others and needed more time to convey their experiences. As such, the interviews were between 60 and 120 minutes.

Demographic questionnaire. The Demographic Questionnaire (Appendix C) was developed to gather personal information regarding: the participant's age, gender, years of education, major(s) and minor(s) in college (if this applies), current profession, age at the time of therapy experience as well as the type of setting, duration, and number of psychologists seen. Participants were also asked to report the country within which they were born, age of immigration to the U.S. (if this applies), as well as their parents' immigration history (if this applies).

Personal interviews. Participants were then asked to talk about how they were introduced to therapy. Where were they introduced to it, from whom, and at what point in their lives? Participants were also asked to discuss the obstacles that held them back from entering therapy. The interviewer used the interview protocol as a guide for exploring and facilitating a discussion.

The goals of the open-ended interview are to identify the significance of the barriers to psychological treatment within the Korean American population and to understand the key processes involved in overcoming them and entering treatment. The participants are asked to talk about the first time they considered therapy and the events that preceded it. The interview is aimed at understanding all of the factors in the decision making process, particularly the obstacles in going to therapy and the way in which they were overcome.

A component of the interview was to determine whether the likelihood of entering therapy would be greater based on the participant's adherence to his traditional ethnic values and identity. To examine the participant's ethnic identity, a part of the interview involved a semi-structured assessment of their ethnic identity and the closeness to which

they identify with traditional values. Participants were asked a series of closed questions and told to respond along a 5-point Likert scale or from a group of preset choices.

Participants were then asked to reflect on how, if at all, their level of assimilation and acculturation to the mainstream culture contributed to their willingness to enter therapy in a more open discussion format.

Suinn-Lew Asian Self-Identity Scale (SL-ASIA; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). This measure was developed to assess the degree of acculturation in Asian Americans. It looks specifically at the cognitive, behavioral, and attitudinal aspects of acculturation. Specifically, the items captured five underlying factors: 1) reading, writing, and cultural preference; 2) interactions and relationship preferences; 3) ethnic identity and pride; 4) generational identity; and 5) food preference. This assessment has been validated in exploratory and confirmatory investigations.

Though the instrument was designed as a self-report measure, its contents were adapted and incorporated into the interview at the end. These findings provided a snapshot of the participants' levels of acculturation and a talking point about their ethnic identities and adherence to traditional values. This portion of the interview is aimed at understanding whether the participants' perceptions of mental health and therapy were influenced by their ethnic identities.

Pilot interviews. Before the first formal interview, I conducted a pilot study with three of my friends, all of whom met the inclusion criteria, in order to evaluate the validity and effectiveness of the interview protocol. The pilot interviews lead to several changes in the final draft of the guided interview protocol. The initial drafts did not account for the positive influences of a family member on going into therapy. Two of the

three participants reported that their family members' endorsement and encouragement highly motivated them to enter therapy; and, had it not been for their participation, they would never have considered it themselves. And based on the feedback and comments from the pilot study participants, I modified the study's guiding questions and the themes which were important to discuss.

The pilot studies also allowed the interviewer to become more familiar with the process of conducting a grounded theory research and the line of inquiry. Important to grounded theory research is the self-awareness of the researcher in how his subjectivity and bias may influence the phrasing of questions and comments. If I don't have an awareness of my biases, it can have a self-fulfilling effect on the participant's data. If I am not careful, I can inadvertently say something about the participant's experience that then influences his line of responses. Practice can improve the researcher's awareness of himself and be helpful in learning how to ask more facilitative questions.

Administration of measures. The type of administration depended on where the participant resided at the time of the interview. If the participant was unable to meet in New Jersey or New York for an in-person interview, the individual was offered a phone interview. An informed consent was sent to the participants' preferred location, in order for them to read, sign, and mail it back to the researcher before the time of the interview. This was particularly important for the phone interviewing participant. Upon receiving their consent form, participants were provided information about the study, e.g. time length, interview topics, confidentiality, and reiteration of the study's purpose, and invited to ask any questions about their participation. Participants were then scheduled for an interview time and day.

Data collection consisted of the demographic questionnaire and an in-depth interview, which included structured questions for understanding the participant's level of acculturation. Time at the end of the interview was reserved for debriefing, where the participant was invited to offer any reflections and questions related to the interview experience. The researcher also provided the participant more information about the study and related readings if there was interest.

CHAPTER 4

RESULTS

Introduction

Maintaining a self-awareness of my interpretive frame of reference and striving to be as close to objective throughout the interview was an important task for this writer. As stated earlier, an interviewer's use of words can establish the conceptual frame from which a participant interprets and responds to the question. In a similar light, this writer's interpretative frame can significantly impact how the narrative data is interpreted. As the primary researcher of this study, I acknowledge my influence on the interpretive findings from the data, and how I derive meaning and substance from the data via my own interpretative lens.

Participants were asked to complete a demographic questionnaire (Appendix C), which included the gender, education level, age upon entering therapy, and the type of treatment setting. This information supplemented the participant's narrative and provided a basic context for their decision-making process. The latter, and more time-consuming, portion of the study was the interview, which examined: 1) the nature of the presenting issue(s); 2) attempts to resolve issues; 3) introduction to mental health and therapy; 4) interests and reservations about entering therapy; and 5) how the participant resolved the ambivalence to enter therapy. Inherent in this narrative was the participant's understanding of mental illness and therapy. The themes on which this writer interpreted the participants' narratives were divided into three categories: 1) the context in which the participant was introduced to therapy; 2) the obstacles that dissuaded and prevented the participant from entering therapy; and 3) the factors that contributed to the participant's

decision to ultimately engage in therapy. The following section will detail the findings from the participants' narratives.

Data Description

Demographic data. The sample consists of eight Korean Americans (2 males and 6 females). Their ages ranged from 25 to 35 years with the mean age of 29.4 years. The average age of entry into psychological treatments is 21.125, ranging from 17 to 27. Six participants received treatment within an outpatient treatment setting (two at the college counseling center, four in a private practice) and two received treatment within an inpatient residential setting. One made the decision to enter therapy while she was in high school, while five entered in college and one at a later time. Two of the participants were pushed into therapy by their parents at an earlier age. At the time of their treatment, three were in Philadelphia, Pennsylvania, two were in Manhattan, NY, one was in Berkeley, CA, one was within central NJ, and one was residing near Los Angeles, CA. All of the participants lived in the United States for more than 15 years, and seven were born in the United States. Six of the participants eventually obtained a graduate degree, e.g., MBA and MAs, while the one participant was in college at the time of the interview.

Profiles of the participants. The table below provides a brief description of each study participant to assist the reader in looking at the data. To maintain their confidentiality, the participants' names have been changed; rough approximations of their age, first year in therapy, and therapeutic setting were assigned.

Table 2.

Participant profiles

Identifier	Name	Gender	Age	First Year of Therapy	Therapeutic Setting
1	Anna	F	30s	1999	College Counseling

Table 2. (continued)

Identifier	Name	Gender	Age	First Year of Therapy	Therapeutic Setting
2	Ben	M	30s	2000	College Counseling
3	Connie	F	20s	2007	Residential
4	Denise	F	20s	2006	Inpatient
5	Erica	F	30s	1995	College Counseling
6	Fran	F	20s	2008	Private Practice
7	Gina	F	20s	1997	Private Practice
8	Harold	M	30s	2004	Private Practice

Results from Suinn-Lew Asian Self-Identity Acculturation Scale. These scores reflect the individual's identification with Asian ethnicities and Western cultures. The final score falls in between 1.00 (low acculturation) and 5.00 (high acculturation). A part from this score, this measure also interpreted the participant's ethnic identification based on the extent to their adherence in Asian and American (Western) values. These responses are found in the last four items of the assessment. The participants' scores on this measure are as follows.

Table 3.

Suinn-Lew Asian Self-Identity Acculturation Scale of Each Participant

Name	Acculturation Score	Classification
Anna	3.14	Bicultural
Ben	3.24	Western-identified
Connie	4.29	Western-identified
Denise	3.90	Western-identified
Erica	3.43	Bicultural
Fran	4.10	Western-identified
Gina	3.90	Western-identified
Harold	3.48	Bicultural

Dropouts. Five other prospective participants had dropped out of the study after communicating with this writer and scheduling a time and/or place to conduct the interview. After several attempts to contact their cell phones and two to three voicemail messages over three weeks, this writer extended one last invitation to participate in the study to which no one responded.

Data Analysis

Thematic analysis: Considerations for entering therapy. Each participant reported that they had considered therapy only after they had reached a “breaking point,” the moment at which their problem became so severe that it was impossible to manage it on their own. In order for an illness to reach this severity, there was likely to have been a build up over an extended period of time. As this paper will detail in the following section, participants were initially optimistic that the pain would simply subside if they allowed it to pass. This illusion of having control over their illness was then met with the reality that their problems were not resolved, the “breaking point,” which was followed by a sense of helplessness and panic.

The majority of the participants felt a sense of helplessness and needed something or someone outside of themselves to help them. Whether they had heard about therapy through a counseling center at their respective colleges or from a concerned friend, who had essentially forced them into inpatient treatment, or experienced a sudden, psychotic reaction to a drug, their pathway to the idea of psychological treatment were as varied as they were unique. What appeared to be common threads throughout the narratives were the intensity of their distress and the severity of their conditions prior to entering therapy. The following section will discuss these factors in greater detail.

Breaking point. The majority of the participants reported an acute period of overwhelming emotional distress accompanied by their inability to cope with it. All of the participants tried to deal with the problem to be of their capacity but it was ultimately unsuccessful. For Denise, her strategy of “plowing through” and “bearing down in <her problem>” simply was not effective. As much as she tried to minimize her emotional pains and focus on other less painful aspects of her life, she was “falling apart” and not able to take care of herself. Engaging in distractions (e.g., recreational drug abuse) and seeking practical solutions (e.g., sleeping when physically exhausted) were two of the most common ways that the study participants managed their stress.

Connie dismissed her problem as a non-issue because she believed that she could eventually abstain from her substance abuse if she truly wanted to stop. During this period, she was “so obsessed” with her body image and weight that she devoted a significant portion of her life exercising at the gym for five to six hours daily; and despite trying to eat healthy, she would lose control in the night and binge on junk foods. Though this cycle would repeat itself with regularity, as a student, it was still manageable because her time was not that structured. In her words,

I realized that I had to leave college at some point, that I had to enter the real world, and that I wanted to enter the real world. I was like, ‘Fuck, this is not going to work anymore.’ ... I didn’t want to hold onto it. I was exhausted. I didn’t want to work out for that long. I wasn’t able to function in life. It was one of those things that I couldn’t hide. I couldn’t do anything unless I worked out for four hours, literally. At least four hours. And I can’t keep doing that.

Months away from her graduation day, Connie was faced with the responsibilities of a career and an 8am to 5pm job and the reality that her gym activities could not be maintained. However, her inability to control her habits and to force herself to stay away from the gym left her with the feeling of being out of control. In her mind, she had decided that the exercise and diet pills were damaging her life and that both had to stop. This was when she thought about her options, one of which was an intensive inpatient program that emphasized addictions and eating disorders. This was when Connie started to consider therapy.

Ben tried to overcome his tiredness by willing himself to be more active and energetic, but simply pushing himself to get out of bed was not enough to make it happen. His exhaustion had been a part of him for more than half of his life, but he did not recognize them as a problem until it became particularly bad during college. In his words,

At that point my symptoms were pretty bad. I wasn't just feeling tired and down, I was feeling miserable. I couldn't get up in the morning and I didn't want to face anybody, especially my roommates because they would say, 'You've been in bed for two days straight, what's going on?' and I didn't want to talk to them. I got angry at them for being worried about me, despite the fact that I couldn't control the behavior or change it. I was able to recognize that something was seriously wrong.

His entire world began to "fall apart" when he could no longer motivate himself to get the good grades that he had in the past. Ben's physical symptoms worsened and he became more isolated than usual, despite the persistent efforts of those family and friends who

tried to reach out to him. He was not comfortable with the care and attention that his condition garnered, as he felt that his friends were burdened by his problems. This sign was a strong indicator of a problem.

Severe emotional distress. With the exception of Harold, each of the participants was introduced to therapy during a time that was marked with great distress. Several of the participants expressed a “longing” to go back to normalcy, a time when they had more control over their behavior, emotions, and futures. Sentiments of becoming more emotional stable and of having a more satisfying and meaningful life were common across these participants.

Gina explained that she wanted to have a sense of control over her thoughts and behaviors. She stated, “I was not sure where I was going,” as she was “recklessly” experimenting with recreational drugs and associating in social circles that were engaging in dangerous behaviors. Gina expressed how “confused” and “tired” she had been and how she wanted to bring her focus back to being the productive, academically talented daughter that she had been in the past.

It was not uncommon for participants to experience such shock and disbelief in their behaviors and eventually arrive at a point where they asked themselves, “What happened to me?!” and “How did I get to this point?” with exasperation. In Gina’s desperate state, she knew that the only way that she could begin to regain control over her life was to seek out help. She characterized this moment as an “epiphany,” after a culmination of “a lot of bad things.” It was time for her to take care of her life.

Denise reported feeling similarly exasperated and exhausted from the lack of sleep brought on by a series of extremely stressful life events. The effect this had had on

her physical and psychological condition made it difficult to perform even the simplest of tasks. In her words,

I was pretty desperate at that point to sleep and not cry and just be kind of normal functioning... because... I guess usually like if I get three to four hours of sleep a day, or a total of 10 hours in three days or something, I'm okay. But, this is two hours within like six days and I didn't get much... it's just absurd.

Her lack of sleep was coupled with three traumatic revelations, each surrounding a loved one. First, she learned that her father had not died by natural causes, as she was previously told, but that he had committed suicide. Denise was given this news shortly after her mother passed away. Both losses were tremendously painful. These events were compounded by the devastating discovery of her boyfriend's series of infidelities with other women. "It just got to a point where I was really bad... I just completely fell apart, like I just completely fell apart... and then I just shut off from the world, I turned everything off..." The world had become too burdensome for her. She felt "really alone" and "just didn't want to try anymore." There was a hopeless tone to her narrative. She "wasn't quite there... just living... and <she> wasn't happy or had any reason or desire to live." In her mind, people caused her pain and grief, even those, like her boyfriend, who were supposed to be there for her. While her friends tried to support her, they were living about 400 miles away from her. They were not easily accessible at the time, and there was a lot that she had to sort through in her life. And while her world continued to come undone, an additional worry that she had in the back of her mind was her genetic predisposition to emotional instability, depression, and suicidal thoughts vis-a-vis her father.

As stated in the earlier section, Connie had been struggling with binge eating and excessive exercising for five years, and her abusing prescription drugs for a year before she decided that “enough was enough.” Prior to this realization, she believed that her exercising habits (six hours per day) which she did not consider a problem of dependence until her life stage could no longer sustain such a rigorous workout regimen.

My eating became a lot worse... I would eat all of this junk food at night... then I would steal my roommate's food. And I knew I wasn't hungry but I still did it anyway. It was uncontrollable and this wasn't really like me and I wasn't sure what I was going to do about it... and I got these diet pills to lose some weight and became really obsessed with going to the gym. I would go to the gym before my practice, and I would say, 'Oh, I'm just trying to get better for swimming,' even though it really wasn't about that. That was probably the point of no return. Everything just went downhill from there. My swimming got worse because I lost a lot of muscle mass and I wasn't eating enough...

Abstaining from her diet pill dependency and reducing her four to six hour workout regimen was more difficult for Connie than she had originally thought. She had to “cut everyone out of her life... and became very, very depressed” in the process, not to mention the deleterious effects that her eating habit had on her body. Connie was months from graduating college and feeling the incredible pressure to start her career and pressed to think about her future with her long-term boyfriend. Nevertheless, Connie was incapacitated by her inability to curb her addictions to exercising and destructive eating habits, which led her to exploring all of her options for help.

Anna fell into a similar state of desperation during her first year at college. With mounting responsibilities and increasing pressures to excel academically, and her difficulties managing her overwhelm and panic, she turned to marijuana to cope. As her tolerance increased, so did her dependency and use of other drugs. Her problems also multiplied. In addition to her episodes of panic and intense anxiety, she had trouble sleeping and had psychotic-like symptoms. In her words,

I thought I was going crazy, and I didn't know if I was going to be like that forever, and I didn't know how to make them go away. I had not slept for several days because I had taken some amphetamines... I was clearly stressed out, and I felt really strung out and paranoid, and so I went for help...

Anna's substance abuse precipitated a terrifying combination of visual and auditory hallucinations, paranoid thoughts, and sleeplessness. Her fear of losing control over her thoughts was a strong motivating factor to seeking out psychological treatment. The time in which she sought out help was similar to the previous participant, who considered help only after her life had been headed in the wrong direction for many months. The severity of Anna's psychological distress was significantly high, as she was reporting multiple episodes of visual hallucinations before exploring her options for professional help.

Significant life changes. Change is stressful and at times threatening; it requires the psychological resources needed to adapt to the new environment. When one's primary means of coping are compromised or no longer available, it can seem especially terrifying. For three of the participants, entering college was a stressful change that brought about other issues. Anna reported the experience of being "uprooted" from the life that she had known and thrust into a competitive college atmosphere. Ben expressed

feeling similar pressures to keep up with his classmates and do well at a highly competitive Ivy League. Both had lived most of their lives in one area before moving to college and had not lived on their own for an extended period of time; and both were hundreds and thousands of miles away from home and without the support of their family and friends. The comfort and familiarity of home motivated Anna to travel back home for weekends, while Ben eventually transferred out of his college in MA and attended a school closer to his family in CA.

By their accounts, entering college was not simply a change in the physical environment; it represented a greater academic challenge for them as there were more talented students in a large setting. Academic success came easily to both participants in grade school and without much effort. However, both Anna and Ben recalled the feeling of overwhelming stress at the start of their college year, as they tried to balance their newfound independence and their demanding responsibilities as a college student. Attaining and maintaining the level of performance that they had so easily achieved in grade school was not always a realistic or healthy expectation to have. Anna had placed so much pressure on herself to maintain her academic success that it had triggered the onset of anxiety and panic attacks and sleep disturbances. In her words,

I was scared of not getting an A. My anxieties about school lead to procrastination, and my procrastination resulted in feels of panic, like... 'Huh! I only have 48 hours to study for this exam!' I felt crazy stress... and that's when I went to the outpatient services.

It was intolerable not to be at the top of her class. When Anna was no longer able to achieve the academic success that she had in high school, she was unable to cope with

this reality and adaptively adjust her expectations. And as her disappointments grew along with her expectations, she became increasingly anxious and panicked.

Academic success was extremely important to all of the participants. Parents instilled the importance of education at an early age. Ben articulated his parents' position on education and their expectations for him to complete his college education at all costs:

Education is the highest of important things in my family. My parents continue to make it very clear. Not to graduate is not an option, so that was something that caused a lot of pressure in me.

Academic success was not a contestable option in his family. It was unfathomable to stop mid-way even if he felt that he had a justifiable reason for taking a break. In high school, when he was too tired to study, his family encouraged him to rest and sleep so that he could finish his work. Their responses conveyed the message of doing whatever he needed to do to complete his studies. And he managed this pressure rather well in grade school; however, the pressure to be efficient and successful in his college courses was problematic for him in college as it manifested in a feeling of overwhelm and hopelessness.

Family and social influences. For many children, their parents are considered the models of behavior. In the case of Fran, whose mother was professionally affiliated with the mental health industry, therapy was viewed as a “healthy way to deal with an ongoing problem” and valuable to anyone who may “need additional support.” Fran’s mother was facilitating a weekly support group for Korean American women through her church. Unlike many Korean Americans, whose negative views of mental health are founded in a culturally based stigma, Fran saw therapy as a positive outlet and encouraged her friends

and acquaintances to seek it in times of trouble. And, naturally, as she was in the midst of a problem that she could not resolve on her own, she thought about meeting with her own psychologist.

Based on Fran's narrative and her responses to the acculturation measure, it was found that she had endorsed a high level of acculturation. Her childhood was open and embracing of the Western culture; as did her parents, who supported her independence, passions, and sense of agency. Fran's parents made it a point to integrate themselves in White American communities. Her father conducted business with Korean and non-Korean Americans, while her mother was involved socially in both Korean and non-Korean American communities. Similarly, Fran's friends were of eclectic backgrounds and ethnicities, not simply of Korean ancestry as her unacculturated counterparts. In social settings, she interacted as comfortably with non-Korean Americans as she did with Korean Americans. Fran's openness to the Western culture seemed very much a product of her upbringing and the subculture of openness that was fostered in her household.

In addition to the family as an influential unit, relationships outside of the family must be considered. For Erica, this included her friends, co-workers, and acquaintances, essentially anyone with an opinion about therapy. Erica was introduced to idea of therapy by a counselor during a mental health outreach event at her school. And when this encounter sparks conversations with her friends about their positive experiences in therapy, did she begin to accept it as an acceptable form of support. Her friends normalized the idea of receiving help from a professional and put the experience of therapy in a relatable context. Coupled with the encouragement of a counselor at the women's center, Erica was motivated to seek more information about therapy.

Thematic analysis: Obstacles in going to therapy. For the majority of participants, one of the main challenges in going to therapy was based on their misconceptions about mental health and the therapeutic process. For Ben and Denise, therapeutic services were thought to be targeting a certain type of person who they could not relate to – “crazy people” and “rich, white people.” Such beliefs reflected their misunderstandings about what they believed therapy was purported to accomplish and their stigma towards mental health. While these concerns were not necessarily reflective of the Korean American culture, as stigmas and misconceptions of mental health were common among many ethnic minorities and recent immigrants, this belief was an obstacle that prevented several of the participants from receiving treatment sooner.

With the exception of Fran, who had expressed positive associations to therapy involvement, every other participant reported that they had felt ambivalent and had had serious concerns about entering therapy. From their responses, these three themes stood out: 1) the different styles of communicating in their households and in therapy. As this paper will discuss later, the participants’ families did not encourage frank discussions about their struggles and sufferings; rather, there was an emphasis on not burdening others keeping one’s emotions in check and allowing the situation to be resolved with time. 2) The negative consequences brought on by their family and friends brought if they found out about their involvement in therapy. 3) The potential waste of time and money or concern that therapy won’t mitigate their problems. What should be apparent to the reader was the powerful role that one’s social and familial environment plays in the participants’ decision making processes. This section provides an overview of the multitude of obstacles that the participants faced as they considered therapy.

Style of communication with family members. The majority of the participants were raised in a traditionally Korean household speaking Korean, regularly eating Korean cuisine, and adhering to the values and norms of the Korean culture. Meeting with a person outside of the family to talk through emotional problems is strongly discouraged within Korean communities. Korean Americans tend to have tighter boundaries with persons outside of their family and refrain from representing themselves in any way that may appear humiliating. Participants were encouraged from an early age to keep personal matters from the public and to speak to a family member, if they absolutely had to speak to anyone. In examining their style of communication, with family members and friends, it was evident to this writer that these relationships did not foster an emotional vulnerability or receptivity to sharing a problem or distressing emotion.

Talking to a non-Korean American, or a person of any background, about personal problems can be an unsettling experience for anyone. Several of the participants also presumed that others would perceive this as a weakness. The Korean culture promotes self-discipline, internal strength, and emotional restraints. As described in an earlier section, the public admission of a problem can have social ramifications if they are expressed within a traditional Korean community.

Erica described her family as the “type that does not express feelings to each other.” The weeks following the passing of her father, she noted that not one family member sought out each other for emotional support. While each family member appeared sad, none seemed comfortable enough to talk about their feelings. In the following quote, Erica described how her family dealt with emotions and observed that a

common reaction to an emotional event was to withdraw into silence and avoid its expression.

Among <Korean Americans> and <within my family>, we don't really emphasize feelings... it's more of a hierarchy about <how feelings are managed> and much more structured <so as to not consciously deal with emotions>... the Korean culture can be rigid in this way, and there's no room for feeling sad like when my dad passed away.

Though her family may have reacted to her father's death in sadness and grief, these feelings were hardly communicated to one another. Each family member was to hold onto their pains and not burden the other. Thus, Erica kept these feelings to herself.

The hierarchical structure within her family stifled the expression of emotions even in response to a significant loss. What does this mean? 1) There was a structure, an implicit set of rules, which prohibited her family members from expressing themselves. There was no value in this type of expression, nor was there a value in acknowledging these feelings within oneself. 2) Expressing intense emotions were threatening and dangerous and were believed to intensify the emotions or make the matters much worse. 3) Emotional restraint was viewed as a healthy form of managing negative emotions.

Gina expressed that her family upheld a similar mode of managing their emotions. She recalled the traumatic instances in which she was chided by her parents for expressing her sadness at the dinner table, as they stated that it was impinging on their right to be happy. How dare she cause her family to feel sad and down on her behalf! Expressing a negative emotion reflected a mismanagement of problems particularly when it is done publicly. Why should the family be punished with feeling sad, simply because

she could not handle her problems on her own? From this perspective, it can seem quite selfish for anyone to express any negative emotions in the presence of another person. In following quote, Gina described how her family responded to instances when she would feel sad.

...if you have things to tell <the family>, then let it be things that cause you to smile, things that are good, and things that bring everyone up... that's good, you should share that, but if something is bothering you, why are you going to bring someone else down in our family? Don't talk about those things... they were trying to tell me that if it could possibly make someone feel uncomfortable or bring them down from a happy state, you just don't talk about it.

And Gina went on to elaborate on how these restrictions forced her to watch what she said around her family and caused her to be vigilant about keeping her emotions to herself. In the following quote, Gina talked about how this resulted in further issues for her.

I was a bottle of emotion, like all over the place. I was bottled up with emotion at home; I bottled up emotion with my friends. It wasn't that it happened all the time, but when I reached my limit, it's like, it's basically like taking a can of soda, shaking it up and dropping it. Like I was, I'd just lose it you know? And then, be so embarrassed about this episode it's like, I mean it was always about something small too, you know?

Similar to Erica's family dynamic, emotional expressions were discouraged in Gina's family and conveyed a message that expressing them would lead to dangerous and threatening consequences.

The inhibition of and expression of distressing feelings had overarching implications in later relationships. It was easier to relate to persons who also avoided conversations about their feelings and persons who were not open to talking about their personal problems. Conversely, it was anxiety-provoking and threatening to engage in a relationship that was based on this type of communication, no matter how beneficial it may have seemed to the individual. This also meant that providing support in a time of distress was defined differently. For Ben, as stated in the following quote, support was often solution-focused, concrete, and planned out.

My family, we don't talk about feelings. So it's not something that I did with friends or in my relationships, it wasn't something that I was used to – talking about things with a stranger... It was always, 'Are you tired?' and 'Okay, go take a nap and then go do some work or homework or whatever.' It was like I had to power through it.

Talking about feelings did not come naturally in part because his family was one that dealt with problems rationally, with little, if any, consideration for the emotion. As with most of the participants, it seemed that Ben's family was quick to offer advice and spent little time actually asking him questions about what was actually wrong.

In Ben's family, distressing situations were managed by "powering through" it, which conveyed the importance of persevering and willing oneself to the goal. Symptoms of "mental illness" were believed to be controllable. As such, emotions could be perceived as the obstacle to mental health. Ben recalled the sense detachment in his family's practical advice.

My family is really loving and supporting, but they are very solution-oriented. We don't talk about our problems, we talk about solutions. And we get things done. I think they created a lot of skills in me that are very good and productive but it created sort of a void in me to develop a comfort level in going to a therapist and talking about my problems and trying to work things out that way.

When Ben looked too tired and exhausted to get out of bed, his family responded based on what they thought would help him. From their perspective, Ben's condition was rooted in his physical health. He specifically mentioned how his parents acted on their own beliefs, never once asking for his opinion; and in their process of trying to help him, they overlooked him. In his words,

Nobody asked me, 'why do you feel so down.' 'Why do you think you feel so bad?' It was always, 'Are you tired?' 'Okay, go take a nap and then go do some work or homework' or whatever. It was like I had to power through it, no one ever asked me, 'What do you think is going on?'"

There was no space for Ben to assert his reasons why he was tired, and it could not emerge in a conversation because his parents did not seem interested. Had Ben shown interest in therapy, would his parents have allowed him to pursue it? He was expected to "power through" the problem. But, what he had wished for was a personal connection with his parents and for them to respect him as a person who has his own feelings, thoughts, and wishes. In retrospect, he wished that they had asked him for his perspective, thereby validating it, rather than imposing their own views about his condition onto him.

For Connie and Denise, their family members strongly advised them not to be vulnerable or trustful of others at an early age. In Denise's words, she recalled what her mother had instilled the belief that pain and hurt were inextricably associated with being involved in any relationship.

...she always used to say to me, 'You are always alone. Everyone in the world will turn your back on you.' You know, I had no one... 'You're going to be all alone.' She always pushed these ideas into me since I was literally... able to understand words.

Her mother's words reflected a strong sentiment about vulnerability and trust within relationships, one that persisted throughout her childhood and on into her adulthood. She described herself as "a super private person," and despite her expressing a strong desire to talk with her closest girlfriends about the problems that had been bearing down on her life, she "couldn't push them out... and vocalize them." This ambivalence also manifested interpersonally via social withdrawal whenever she faced a problem, which ultimately resulted in her alienating the very friends who had tried to offer support.

Interpersonal dynamics. Certain family dynamics seemed to be associated with a willingness to obtain help from others, be they acquaintances, friends, family, or professionals. As stated in the previous section, Denise described herself as being independent from an early age. In her words,

<My relationship with my mom> was the same as <when we were together or far away from each other>. I couldn't be like completely me around her. We were never like super, duper, close like that, like people who tell each other everything... but we were super, duper close in how we loved each other.

Unsurprisingly, Denise reported enough difficulty in talking about her struggles with another person that she chose to hold it even in the most difficult and emotional periods in her life. Growing up without a father in an environment where emotions were not acknowledged or expressed, this participant did not have the type of relationship with her mother to speak honestly about her feelings. Instead, she reportedly withdrew and compartmentalized these aspects of herself from her mother; showing her mother those sides of her that she was able to comfortably communicate, a style of interacting that was also evident in her friendships.

Despite a lack of direct support from her mother, Denise was still able to experience her mother as loving. Denise described her mother's love as "an absolute, a given," and this was indisputable. Though her mother was "kind of mean, verbally mean," "it was very clear <to her> that she loved <her>..." This love was demonstrated through her mother's "infrequent" and random acts of physical affection, e.g., asking her to sit on her lap to cradle her, even though the participant was physically bigger than her. It was an act of sacrifice," an unconditional commitment, that did not have to make rational sense.

Still, her mother was neither open to sharing her emotions nor fostering a space for Denise to confidently know that her mother would protect her if she was in pain and talk her through her emotions if she was hurt, sad, or angry. As the other participants have also stated, there seemed to be no positive value in expressing one's emotions in Denise's household, either. Talking about intimate feelings was viewed as threatening because it opened her to a potentially critical statement from her mother. As such, when she had thoughts about killing herself, she went "off the grid" and disconnected from all

of her friends. This participant's closest friends, who were more than 300 miles away, tried to contact her to no avail; and eventually tracked her through the front desk employees at her residence and her peers in graduate school.

This pattern of turning away and withdrawing from her ready supports was a pattern that reflected challenges in entering therapy. The question was not whether she had access to people who may be able to support her; it seemed more to do with her sense of safety in sharing herself with others. Suppression and minimization of affective experiences were an adaptive means of coping with an intolerable situation. Understandably, such individuals then are likely to have less interest or motivation in uncovering and confronting, much less communicating, their emotions and personal thoughts with a psychologist.

Talking about a traumatic memory can be more burdensome to share if the speaker has to help manage the listener's affect. In other words, if the listener has an inconsolable negative reaction to a person's story, chances are that the speaker will feel responsible for causing pain on that person. For Ben and Gina, whose family members seemed to over-identify and internalize their distress, sharing pains and seeking advice from trusted persons resulted in additional stress. Ben described his reluctance to share any sort of distress with his family members for this reason. In his words,

I don't want to tell my mom about my personal things because she would get all upset and worried. And I don't want to tell my sisters about what's bothering me because they'll try to help me out or send me some extra money.

Whether it was the reaction his mother had when he told her about his problems or the apparent disregard of his feelings when he told his sisters, this participant was not

comforted by his family's reactions to his distress. Ultimately, Ben did not want to bother or burden his parents with his problems. Remaining silent and keeping his distress away from others was as much in the service of protecting the emotional states of others as it was in protecting himself.

Denise and Gina have learned to discern when to withhold sensitive pieces of personal information, like their therapy involvement, from others. This delineation became clearer over the years after many conversations ended with their feelings of rejection and embarrassment. They learned that sharing was not beneficial to them, and realized that their family and friends were not going to change their understanding of what was emotionally helpful. In Denise's words,

I realized, oh God, it's better to let her believe what she wants and just let her believe what she wants and I will keep that façade up for her. And even if that's not me, for presentation purposes, I will be that, but that won't necessarily be my truth... I tried now and then to open up to her once and awhile until I was maybe 18 to 19 years old... and then I just completely gave up. I just acknowledged that this is how it had to be.

Understandably, Denise adapted her way of interacting with peers according to their needs, in order to preserve her relationship. She chose to avoid frank discussions about herself even if it meant that her mother would have an inaccurate perception of her. Later, as she thought about going into therapy, the idea of talking to a psychologist seemed skeptical. It contradicted all that she had known about confiding in others. It seemed especially counterintuitive to her to depend on someone else.

Ben, Denise, and Gina voiced a concern about the nature of therapy and the types of conversations that they were expecting to have with a psychologist. In relation to his family's inability to tolerate their emotional distress, Ben expressed a concern about the consequences of if his psychologist would not be able to tolerate the intensity of his distress. The thought of his psychologist reacting in overwhelm, as his parents had, evoked a greater sense of distress in him. What would then be the benefit of going into therapy? Or a reason for him to seek support from his peers with this thought weighing heavily on his mind? Consistent with this concern are his sensitivities to feeling responsible and guilty for his friends when they feel distress in response to his depressive symptoms. After he told his friends to "go away," during a time when he was not feeling well, he felt "horrible."

Some of the participants anticipated that their parents would be upset and distraught by their participation in therapy because they viewed the reliance of therapy as a "sign of weakness." For Anna, it was important to preserve the esteem of the family by concealing from her father how weak and "broken" she became at the hands of her father. She intended to avoid any conversations with her father about how he had "fucked up" her life because it would "destroy" him and cause her to feel responsible for his pains. Similar to the aforementioned participant, Anna found it easier to reveal as little as possible about her issues. In the following quote, Anna explained her reasons for attempt to "save <her> father's face" and shield him from her painful realities or her reasons for being involved in therapy.

I have this thing where I'm still trying to save my family's face... I think from having my dad know how badly he fucked up... I didn't want him to know how

badly he messed up because I didn't think that he could handle it... I don't know if he would be able to understand it. He would be all stressed out. It also has to do protecting myself because I don't want him to know and worry about me. If he starts to worry, I associate that with him wanting to hit me, yell at me, and control me. As long as he doesn't worry, I'm okay... and I've learned how to speak that language to prevent situations from arising.

Compartmentalization was an adaptive function throughout her childhood that allowed her to manage further problems with her father. In telling her father all of her issues, she would be conveying the extent of his inadequacies as a parent, which seemed disrespectful for the child of a traditional Korean American parent. At worst, he could have felt impelled to physically punish her for saying such words. In the following quote, she was still trying to resolve this need to protect her father from her emotions.

I'm trying to still "save face," even after all this time... my father is very much like a child, and he is very much helpless... I don't think he would ever recognize that, and so it's like my shit to hold and that's why I'm in therapy because I have to work on those issues.

In a way, Anna's attempts to "save" her father's "face" reflected the way in which she handled intolerable emotions. It seemed easier for her to be resentful and angry with her father from a distance than it was to communicate honestly with him about her childhood because he seemed unable to handle such a topic. The trouble in having to talk about her father may have presented another obstacle on Anna's path to therapy. Uncovering and discussing how her father mistreated certainly was not an easy or exciting conversation topic. There was the potential of reopening any of the traumatic wounds that she had been

trying so hard not to expose. Therapy, for this participant, could have represented the painful undoing of all the ways she had attempted to avoid her painful memories of her father.

Ways of conceptualizing and coping with emotional distress. The type of coping strategies and options may be constrained by one's environment and limited by one's exposures to the way that family members and friends view and deal with issues related to mental health. In the following quote, Ben detailed the reasons as to why he went through a series of medical tests after his sister, then a medical student, recommended him to visit a doctor for a medical examination. Her belief was that his physical tiredness could have been linked to a hormonal imbalance or a neurochemical issue.

And my sister, who was in medical school at the time, suggested that I get my thyroid checked out. And so I did. Because I still didn't realize what was going on. And it was actually in going to these doctors and telling them that I have symptoms and getting these blood tests done and having them all come back negative, that the doctor then asked me if I had been seeing a psychiatrist.

There were several limitations in his understanding of mental health. First, Ben had no idea why he was feeling so tired. In other words, he did not have any theoretical frameworks from which to conceptualize his physical tiredness as an issue with an origin and a means to resolve it. This was evidenced by his hopeless and accepting attitude towards his ailment and his belief that his problem could have been due to an underlying physiological issue.

"Normal people," like himself did not have psychological issues; these were behaviors exhibited by "homeless people," who often "talk to themselves" and act in

unexpected and “crazy ways.” There was no reason to consider his exhaustion a sign of mental illness. “It just was because it has been around since I can remember.”

Throughout the interview it became clearer to him that his unfamiliarity with mental health made it impossible for him to even consider his problems to be psychological.

What prevailed in his mind was the physical component of his depression, as emphasized by everyone around him, and his inability, or his “lack of will,” to fight past his hardships.

Denise viewed and approached her problems as her mother had taught her to handle problems. Throughout her childhood, Denise received the sort of “tough love,” where she was expected to take care of her problems by herself and to “suck it up” when things started to become difficult. Her mother forced her to push herself as she had been pushed throughout her youth, and Denise was, thus, offered little consolation and support when time were especially challenging. In the following quote, she described one example of her mother’s toughness.

Even when I was sick, she would be like, ‘Suck it up,’ you know like when I had a 104 degree fever in 5th grade, she still made me go to school... that’s just how it was... and she was a nurse! But it didn’t matter because you were supposed to suck it up.

Denise was expected to pick her own self up. When her body was weak, she had to be strong. There was no one else to rely upon; this was her mother’s point and her life to this point. Her mother was “a very intense person... she was always a very stubborn person and a fighter.” After losing her husband to suicide earlier in the marriage, Denise’s mother had to raise her child without anyone else’s support; and with the unexpected and

traumatic loss of her husband, it was understandable for her and her mother if they saw the world as “a cruel and lonely place.” To engage in therapy, and to confide in another person, meant that Denise would need to overcome her issues with trust in the other.

All of the participants have had some relation to Christianity. Many were raised in a devoutly Christian household, one which was likely to view “mental health issues” as manifestations of a spiritual deficiency or a lack of faith. Within Erica’s household, she was pushed by her parents to pray when faced a difficult situation; her mother would tell her that prayer was the first and only route in good health. Not praying “hard enough,” or the general lack of prayer, was then the root of mental illness. If they knew that she was involved in therapy, “<they> probably would have told <her> to pray” and criticized her in the process.

Harold, who has been a devout member of the Christian church since his early youth, discussed his reasons why psychological health was not factored into his understanding of overall health.

I came from a church context that didn’t really believe in <mental health and therapy> stuff and that wasn’t really important. The important stuff was like Bible study and prayer, you know? ... my paradigm was to just have faith in God, <rather than ask questions> like, what are you feeling, what are you going through, or about how you are grieving and things like that. That was not in my paradigm whatsoever. So, by that, I meant it was all black and white cookie-cutter like, you know, if you have “x” problem then you just do “y” and that “y” is usually to read the Bible or pray.

Like Erica, Harold was taught simply that it was important to have faith in God – that all of life's problems could be resolved solely through commune with God via prayer and Bible reading. His spiritual beliefs did not account for the psychological or emotional dimensions of health. Prayer was the answer to anger and sadness; a relationship with God was the answer to envy and resentment. With such clear cut direction, there was no space for Harold to explore his emotions, as this was not an important value within his church system. While his church encouraged social interaction and communication through fellowship, it was not necessarily a place where persons would form intimate relationships. As in Harold's case, emotional issues were not talked about but avoided or privately dealt with through prayer.

Logistical barriers. Life circumstances presented additional obstacles that Anna, Connie, Denise, and Gina had to overcome when they decided to enter therapy. Logistical issues, such as the availability of services, financial limitations, physical distance, time, or a means of transportation were some of the more common challenges in entering treatment. Though aid-based programs exist, knowing that they are available to the public often requires a resource. If resources are limited, an individual's interest in therapy is almost inconsequential.

Therapy can be a costly endeavor; it can be short of \$100 an hour to more than \$60,000 a month, depending on the consumer's need and the preferred treatment setting. Many of the participants sought outpatient treatment services at a college counseling center for free or at a clinic that offered an affordable sliding scale rate. However, for Connie, who was committed to entering an inpatient treatment rehabilitation center, the monthly cost was between \$30,000 and \$60,000. As a college student, this price was

simply unaffordable without support from her family or through her insurance plan. In her words, “Cost had become a very big issue.” This challenge is not limited to seekers of private inpatient facilities, as the \$100+ fee for a weekly, 45-minute outpatient therapy was too expensive for participants, particularly those who were without health insurance.

One costly challenge of entering outpatient therapy is finding a trustworthy and reliable outpatient psychologist. Denise explained that it required more time, money, and patience than she could afford. She compared it to finding the right confidante to talk to about her problems. In her words,

You know how you could talk to like 100 friends and there just might be one friend that says the right thing... finding the right person to talk to... like there are different ways to deal with your issues, that fits your situation, and fits you personally and those who are involved... the right match <in a psychologist> can be very costly and very timely, time-exhaustive.

Denise seemed overwhelmed and exhausted by the thought of identifying a compatible psychologist among the hundreds in Manhattan, NY. It’s like “finding a date among a huge, random mass of men.” She did not have a savings or a job or health insurance, and the least expensive fee quoted to her was \$100. To pay her way through the initial intake interview for the first two sessions, before she had any confidence in the psychologist’s abilities to help her, seemed too high a price for her to pay. Why pay one to two hundred dollars for therapy for one to two sessions to talk about painful things if she was not comfortable with that psychologist? Understandably, it could potentially be a very costly risk to invest her finances into a service only to determine several sessions later that the “match wasn’t there.”

The lack of availability and the service times almost deterred several participants from participating in therapy. Connie's window of availability to enter an inpatient treatment facility was limited to the three summer months, as she was prepared to start a full time job in the fall. Given her preference towards a rehabilitation clinic, they needed to have availability during these months, or else she would look elsewhere. "I asked them what times they have available for me to go in... some places didn't have any availability, and I needed to do this soon." There was already tremendous pressure on her to find help, without the need to fit it in within a short time period. If there were no facilities with availability, Connie would have decided not to seek help.

Social implications (stigma, judgment). Most of the participants were concerned that their family, relatives, and friends would judge and criticize their decision to go into therapy if they knew. Their family's opinions of them seemed to carry a significant weight, which was enough for them think twice about doing anything that could be frowned upon. Why were their family members critical? According to each of the participants, their family's negative views of therapy were based on the stigma associated with mental health. These participants were able to relate to their families' negative sentiments about therapy at an earlier point in their lives. As stated earlier, several of the participants considered therapy a service for "crazy" people and individuals who were psychologically weak and incapable of managing their own lives. It was not a surprise that their parents continued to uphold this negative view.

All of the participants but Fran reported that their family members could potentially react negatively and strongly to their involvement in therapy. This was enough of a reason for a majority of participants to avoid a potentially heated encounter

by disregarding the idea of therapy all together. Ben thought it was fruitless for him to even entertain the idea of therapy while he was living with his parents, as he was comfortable with having to tell them. He described this in the following quote.

I think that as long as I was living with my family, I don't think I would have <gone to therapy>. If I was living with my family and going to therapy, there was no way that I could have kept it private and so... do the pros of therapy outweigh the fact that my parents are going to be worried? I'm not really sure about that. It didn't, so I didn't do it... I didn't tell anyone that I was going to therapy. I wasn't certain that they would have a negative impression of it or any judgments towards me, but I didn't think it was worth the effort to find out.

He had nothing to gain, and much to lose, from telling his parents that he was going to therapy. What would have been the benefit of telling them? His mother would have been “extremely upset” by this news, which would have caused Ben to feel terribly guilty and responsible for hurting his mother; thus, making him more distraught than he was before. Hiding his therapy appointments from them was not an option, as the possibility of “getting caught” was too high. While Ben was living with his family, there was no easy way to keep up with this schedule.

Connie and Gina also disregarded therapy because of how their family may interpret their actions. From the traditional Korean sense, therapy was perceived to be a vehicle for 1) incriminating and punishing incompetent parents who were unable to properly care for their children and 2) humiliating family members by revealing all of their “mistakes” and inadequacies to the “public,” via a psychologist. Visiting a psychologist violates the values and precepts of the traditional Korean culture. Thus,

doing so intentionally, even if it was solely intended to better oneself, could evoke powerful feelings of guilt and wrongdoing in the participant.

This obligation to manage the other person's emotional state was expressed by several other participants. Admitting involvement in therapy was not easy to do with friends, either. Depending on their closeness to the friend, and his or her level of openness to therapy, some participants were able to share their experiences in therapy. For Erica, whose friends were multicultural and largely from diverse backgrounds, she was cautious about how much, if at all, she would disclose to certain groups of friends. In the following quote, Erica talked about which friends would know, why she did not feel comfortable with others knowing, and how she would keep it from these friends.

Like even amongst my Asian American friends, I don't like to tell them... I'll tell my close friends but I won't tell people I don't know that well because I don't know what kind of judgment they are going to form about me. And so I'll tell my Korean or Asian American friends who are close to me. I see a therapist on Wednesdays and this disrupts my social life. So when I tell people, unless they are my close friends, that I'm working late and that I won't be there until 9. So, even though I want people to go, I'm still private about it.

Rather than explaining her reasons for going therapy, and fearing their judgment, it was easier for her to avoid the conversation all together. She went on to say that a higher proportion of her friends in New York knew that she was in therapy simply because they were in therapy at some point or knew someone who had. In this social context, going into therapy seemed more like the norm. When she shared it within these circles, her friends did not react in surprise or with question but acceptance and care.

Uncertainty of therapy. The majority of the participants had a dismissive view of therapy, and what the experience was able to offer them. Their misperception of therapy fostered their reluctance and uncertainty about its benefits. Sharing a problem with a friend was anxiety-provoking for some of the participants. Ben, Connie, and expressed ambivalence about the training of the psychologist and this person's ability to tolerate the emotional intensity in his stories. "Was this person going to grill me with questions?" "I needed some help, but was this person able to help me?" "Was <the psychologist> be able to handle what I have to tell her? Or was this psychologist going to react with overwhelming anxiety as my parents have done in the past?" Lots of questions, most of which could not be answered without meeting with a psychologist.

Ben described his fears about the therapeutic relationship in the following quote. His concern was founded on conversations he has had in the past with people who were trying to offer him advice.

There were a couple things that I was worried about. One was that therapy would make me upset, that I'd sit there for an hour, and I'd be angry and then go home and feel bad. And then next week, I'll feel that again. The second worry was that I didn't want to feel pressured to answer any questions. I was afraid that the therapist would be too assertive and really pull out things that would make me feel really uncomfortable.

His initial fears and reservations about therapy seemed to be related to past incidences where he had sought out support. He seemed to remember most clearly those interactions where he ended up feeling misunderstood, invalidated, and frustrated. Over the years, it

became increasingly difficult to ask for support from his loved ones because their advice caused him to feel more frustrated.

These relational frameworks were vital in determining the initial impressions of therapy. Participants who engaged in emotionally supportive relationships, such as Fran, were more comfortable developing intimacy with another person and seeking their support during tough times. However, for Ben, Denise, Erica, and Harold, this did not come as naturally. For instance, Ben frequently engaged in isolative activities, such as origami, after he fought with his parents or in the midst of a stressful period. Receiving support through a relationship was doubtful at best.

I wasn't sure how I was going to respond. Like, if it's going to be uncomfortable for me, or if it was going to be easy... there was a little bit of anxiety and it wasn't because I was expecting anything but because I didn't know what to expect. I sort of knew what the process was, but because I didn't have a continuous experience in it with family or with friends, I wasn't talking about working things out. It was just something I didn't know or what it was like on a first hand basis.

These concerns were partly based on formative relationships in his past that were not viewed as emotionally supportive. If talking about personal issues and being vulnerable with his emotions was an anxiety provoking experience, then how much more terrifying would it be for him to enter into a therapeutic relationship? He did not have a favorable impression of therapy. This uncertainty seemed to be the cause for his anxiety.

I didn't have an impression of it. The main thing was that I didn't know much about it. It wasn't a negative or a positive, it was just, 'I don't really know much.'

It was limited to that homeless guy on the street talking to himself, thinking that guy is crazy. That's how far my knowledge of mental health went.

His understanding of mental illness was limited to 1) the most severe psychological disorders in the diagnostic manual and 2) associated with an unenviable group of people who were often viewed under a negative light. In other words, it was an obvious disincentive to be associated with a "homeless, crazy person." This view that therapy was exclusively for "crazy" people was shared by other participants, as well, one of whom (8) expressed his bias towards anyone in counseling as having a severe problem.

My understanding of counseling, people going to counseling and all that stuff was that it was for people who were terribly disturbed. People with like extreme schizophrenia, whatever it might be, you know? I was very judgmental towards people who went towards counseling... like these were some f'ed up people.

His judgments towards people in "need" of counseling and therapy made it difficult for him to enter therapy. Why would he choose to be associated with "f'ed up people?" It was clear that he wouldn't. His understanding of people with a mental illness carried such a negative association that there was no space for him to reflect on his own issues in a frank manner. Therapy was relegated to a certain group of persons that did not include him.

Personal relevance in therapy. In relation to the last section, several participants asked this question due to their uncertainty and misperceptions of therapy. Denise pondered this question as she thought about going into therapy. Her perception of therapy was based on her peers and acquaintances from school who had participated in it. Therapy was for "rich, white girls, who didn't really have that serious of a problem" and

for people with “extremely serious issues.” She assumed that therapy was for persons with eating disorders, like bulimia, or problems related to body image, attention issues, and oppositional behavior, none of which she experienced. There was also a cultural divide. As a Korean American female, who could not relate to these White American peers, Denise doubted that therapy could be helpful to her.

Previous experiences in therapy. Anna, Ben, and Gina had been in therapy before they made the choice to do so for the first time. Anna was mandated to counseling and family therapy after her father had emotionally and physically abused her, and Ben’s father scheduled him an appointment with a psychologist upon receiving a recommendation from his medical doctor. Their decision to go into therapy later was partly contingent upon the impressions they formed from their past engagements with a psychologist. Were they helpful? In short, their answers were no. Both participants left therapy shortly, after one to three sessions, because they were displeased, to say the least, with what the psychologist had been doing.

The Department of Child Protective Services mandated therapy for Anna’s family after it was reported that her father had verbally and physically abused her. By her account, the three therapy sessions she had seemed “pointless” and “ineffective.” The therapist appeared inexperienced and under-trained; and she did not seem to know how to manage them. To Anna, it was a “waste of time.”

For Ben, his visit to the psychologist’s office came unexpectedly because his father had not told him about the appointment until the day of the meeting. “My dad was like, ‘We’re going to a therapist, and she’s going to ask you a bunch of questions about your life.’ ... and then, all of a sudden, we were sitting in this room.” Though his father’s

impromptu call was not out of the ordinary, as there had been enough occasions in the past, where he was told he had to go to something, to even notice that it was sudden and unexpected. This seemed to set the table for how the meeting would progress. From the moment he entered the waiting room, Ben felt unsure and confused. His environment looked more like a home than an office fit for a professional or a doctor, and this did not sit well with him. When the psychologist asked him all sorts of personal questions, none of which he was expecting, he was taken aback because this person was a stranger and because it was tough to provide a frank response with his father in the room. She asked him questions about whether he has ever had thoughts about killing himself. For an individual unfamiliar with this type of interview, it could understandably border along the category of “too personal.” He stated that he felt extremely uneasy and uncomfortable because he was “put on the spot” throughout the entire meeting, and he did not know the reason why she had asked all these probing questions. Though this was the only time he had consulted with this psychologist, the fear of having to answer such questions continued with him into his initial meeting with a psychologist years later.

It was an “odd” experience for Ben. Not only did he not know why the psychologist was asking him such personal questions, he was concerned with what she would do with his answers. From the beginning, it seemed that the situation was out of his hands – the family doctor had recommended that his father schedule an appointment with a psychologist for him, so this had occurred without his knowledge. With little time to consider his appointment with his psychologist, the participant was not able to prepare for it. He emphasized several times throughout the interview that it was incredibly “uncomfortable” and “awkward,” one that would leave him with a negative impression of

therapy for many years. It also validated his belief at the time that talking with another person about his problems did not help but rather exacerbated the issue.

For Gina, her first meeting with the psychologist ended abruptly and badly. Her father scheduled this meeting with the psychologist after he had deemed it necessary for a “professional to talk some sense into her.” This was not a decision that Gina had made but a meeting that had been pushed onto her. Still, she was comfortable enough with the psychologist to confide in her until her psychologist brought her father back into the room and brought all of it out into the open without her consent. In her words,

I totally felt that she told me that I could trust her, that I could tell her these <personal> things because I obviously needed to talk about it... and I’m almost certain that I asked if she was going to say anything to my parents because I couldn’t imagine why I would have said a lot of the things that I had if she wasn’t going to agree to keep everything that I had said confidential...

Despite establishing enough rapport to disclose personal issues with her psychologist, her parents eventually found out what she talked about. Her psychologist had violated her trust and irreparably damaged their relationship, which discouraged her from revisiting the idea of going into therapy until many years later. She went on to discuss the psychologist’s “poor judgment” in “putting everything out on the table,” regarding her feelings towards her parents and about her Korean identity in front of her father. The explosive argument that ensued as her father erupted and explosively left the room came soon after her psychologist tried to discuss medication options for her.

...I was speechless... I <didn’t> have time to have a reaction because I was paralyzed with fear of retribution from my father. My dad was extremely

argumentative... completely explosive and could not handle what was being said... <The psychologist> betrayed me... even till this day, I would say that she shouldn't have said a lot of those things, you know? ...she screwed herself because she mentioned that there is such a cultural difference <between my father and I> and felt that it would be a good idea to put me on medication; and that was when my dad was like, no it wasn't. He yelled at her and then he left, and then we all left and that was it.

The psychologist emphasized the importance of her cultural differences, aspects of the culture that she did not explore with either the father or the participant. And then, the session ends, with this participant feeling betrayed and hurt by her psychologist. She had “nothing positive to say about her or about therapy” at that time. When she reflected on this memory, it was evident that her meetings with this psychologist left an extremely negative sentiment with regards to her views of therapy.

For Denise, she did not feel safe or comforted at the thought of being in an inpatient psychiatric hospital setting. She feared that the psychologists and psychiatrists treated their patients with apparent disregard. She discussed how the unit psychologist did not care about her wellbeing in the following quote.

Yeah, it was way too professional for me because... after the session was over and he was setting up our next appointment, he would look at his computer and figure out the schedule <as if to ignore me>. And if the phone rang, he would become like a completely different person, you know? ...he was not comfortable at all.

After she revealed to the psychologist the personal and most painful parts of her past, the participant saw her psychologist resuming his business, unfazed by what he had just heard. From her perspective, how could he appear so nonchalant, as to treat her story with such little weight? This transition into and out of session seemed to be far too formalized and artificial, which caused her to lose trust in the psychologist's care and attention to her wellbeing. It seemed unempathic and disingenuous to her, which left her with a negative impression of mental health.

Thematic analysis: Processes of entering therapy. Each participant arrived at the therapy office on a path that was entirely their own. This section details the participants' processes of entering therapy and identifies the factors that weighed into their decisions. They had exhausted many of their available resources and determined to ameliorate their distress. For some of the participants, push came to shove, and their problems became so severe that they had to address them. Others had the support and encouragement of friends and loved ones.

Each participant found a way to compartmentalize their lives and withhold certain aspects of it from concerned and/or critical family members to avoid uncomfortable conversations in reaction to their involvement in therapy. With the exception of Fran, each of the participants had been concerned about the criticisms of their family and friends. This process involved weighing all of its consequences and eventually coming to the decision that therapy would benefit their lives.

Push comes to shove: Severe enough Aside from Harold, every participant acknowledged that they had had a severe problem, one which was impossible to manage on their own. As stated in an earlier section, some of the participants (Anna, Ben, Connie,

Denise, and Gina) had been very desperate for help as their primary coping methods were not effective. Despite efforts to manage their issues by themselves, the problems persisted and even worsened in the case of Anna, Connie, and Denise. In Connie's words, "How did I get so messed up that I am the way I am now? I just hated myself, I really hated myself." They needed help – the type of support that went beyond the understanding of their closest friends.

Ben's life became difficult and unmanageable when he started to display signs of exhaustion. Ben expressed that he was highly motivated to explore the benefits of therapy when he started to sense that the symptoms were returning. Just as Connie had told herself that she needed therapy to feel better, Ben was determined to feel better and to overcome that which was disabling him from living his life and completing his studies. The daily lives of these five participants were seriously interrupted by mental illness. When symptoms were severe and unmanageable, their level of helplessness and desperation increased. When they were at this point, they came to realize that 1) they had a serious problem; 2) they needed to seek a support outside of themselves; and 3) they were introduced to the benefits of therapy and seriously considering it as an option.

Once Ben determined that his problem warranted the attention of a psychologist, his family's criticisms became insignificant; he needed to care for himself. That was also the case for Connie, who was put in her long hours of research once she made the decision to enter an inpatient residential treatment facility.

By deciding to get help and enrolling somewhere, I also felt a sense of hope. I was looking for hope. I was looking for anything that would provide something

different than what I was experiencing... I have to get better... I had to move on with my life and have a family to consider... I wanted more for myself.

Connie was no longer ashamed by her desire to go into a treatment facility. Her symptoms were all-consuming, and this was apparent to all of her family. Though she had other obstacles to overcome, e.g., parents' financial support, as this writer discusses later, she knew that she needed the support provided in therapy. The need to talk to a professional helped to outweigh any of the obstacles that these participants had towards therapy.

Erica admitted that she needed to meet with a professional to resolve some of more serious personal issues. While she used her friends for support, there were certain things that she could not comfortably disclose. Some issues were so distressing that she could not bear to share it to her friends she was adamant that they couldn't help her. She needed to have a sense of confidence in the professionally trained psychologist. In her words, "I was talking to my friends about <the issue>, but it's really hard because I wasn't sure if they could help me. What I really felt I needed was to talk to a professional." She described a professional as someone who was trained not only "tolerate <her> <distress>" and support her, but someone who could provide hope that her issues could be resolved. Though her friends and loved ones were able to provide a listening ear, her problem required an expertise of a psychologist. As stated earlier, many of the participants entered therapy when their psychological issues were too severe to manage on their own.

Academics and work. Academic achievement was the benchmark for a successful life. The pressures to "succeed" academically and in work preceded therapy for two

participants, Anna and Ben. They reported going into therapy partly so that they could perform better academically. For Anna, therapy represented a hope to overcome her dependence on substances to manage her academic anxieties. For Ben, he simply wanted to succeed in school so that he could put himself in good position for medical school. “<On one hand>, I didn’t simply go into therapy to get ‘therapy.’” In other words, his motivation for going into therapy was not necessarily because he had an interest in improving his psychological health.

When Ben began to consider therapy, his depressive symptoms were becoming a problem. He started to feel exhausted, and he was sleeping more than usual. This participant revealed that he was hoping that therapy would allow him to focus more efficiently in class and improve his level of motivation so that he could do better in school. The potential improvement in their academics trumped every other reason not to go into therapy, even if they had concerns that their family would react with judgment and criticism.

<I didn’t go into therapy> because I needed treatment for my depressive symptoms, because I needed to not feel so down. I didn’t really care if I felt happy or not. What I needed was to finish school – I needed to do better in my classes and if going to therapy was the way to do that, then that’s what I was going to do.

At the crux of this participant’s therapy was not his wellbeing but rather his need to address any problems that prevented him from meeting his parents’ expectations of him. His exhaustion, hopelessness, and sadness were obstacles and hindrances to his academic functioning, and nothing more than this. Skipping or dropping out of college was never a viable option.

On a general level, each participant wanted their lives to go back to “normal,” or what they had been used to, whether it meant that they wanted to be the academic superstar, or drug-free, or capable of going to work. For Connie, Erica, and Gina, this was their impetus in entering therapy. Stress had pushed their lives into a gradual decline and compromised their abilities to concentrate and to focus on their studies efficiently. Connie entered therapy prior to starting her work, and felt more comfortable and entitled to make this decision, because she needed “something” that would curb her emotional distress in order to start work three months later.

Her parents did not respond in protest or anger, as she had imagined, when she told them about her problems. She explained that this may have been because her problems had already been apparent to her family and caused enough concern that they were open to whatever supports she recommended. In a similar way, one participant (2) noted that his parents were more open to seeing him in therapy if his reasons for attending were framed in terms of academic reasons.

Compartmentalizing life and therapy involvement from others. All of the participants expressed a need to determine which family members and friends would not judge their decision to enter therapy. None of the participants volunteered to tell their family about their therapy involvement, and few were open to sharing this information with their closest friends; it was a personal endeavor. To some participants, like Fran, it was not a big issue to tell her parents that she was in therapy. They simply accepted her decision and expressed their concerns for her wellbeing. However, she was the exception. Connie had to tell her parents because she needed their financial support. She was on the

other end of the spectrum as it was so terrifying that she had her sister intervene and talk to them in her place.

Denise was also inclined to keep her visits to the psychiatrist's office and her use of psychiatric drugs private. She had serious concerns about how her best friends would perceive her after finding out that she sought out help for her psychological illness. When she was admitted into an inpatient psychiatric hospital and out of contact with her friends, they were concerned and confronted her on where she had been. To her surprise, her friends fully embraced her as a friend who needed their support and responded with attentiveness, care, and a list of referrals for qualified psychologist. She detailed this experience in the following,

Finally, when I got out, I realized that my close girlfriends, with whom I wanted to talk, they were there for me, you know? And they didn't judge me, and they truly, like it was real love. It wasn't just that they were there or they were just friends, it was more like they were my sisters, you know? Because... they never judged me for <being in a psychiatric hospital>. They were completely there, unconditionally accepting, without asking any critical questions – no when, if, or how, they were just there.

Contrary to Denise's initial fears, her friends were simply present and responsive to her needs. They were not there to question her motives, shame her, or highlight her deficiencies. In realizing their intentions and empathic response, she was more willing to enter therapy. She had slowly began to develop supportive friendships and developed the ability to communicate their problems it was a slow process of building trust in her

relationships with her closest friends and experiencing the relief of sharing a burden with a close friend.

Ben acknowledged the possibility that his parents would react negatively and attempt to dissuade him from involving himself in therapy. The consequence of his parents' reactions weighed heavily on the timing of his decision. What was the likelihood that his parents would find out? What would happen if they did? Ben would ask himself such questions and weigh the pros and cons of therapy. Ultimately, was it worth it? Ben was almost certain that his parents would react negatively. Thus, he decided to keep this information private especially from his parents. Having to explain his involvement in therapy and manage his parents' reactions and questions was simply not worth it.

When Ben eventually entered therapy, he kept it to himself. He understood that his parents have a stigmatized view of mental health and that these deeply rooted views were unlikely to change.

I feel like there's a stigma... it's a misunderstanding... when you tell someone you feel down all day because you have depression, it's really difficult for someone who hasn't experienced it to really know what that's like. And I think that misunderstanding, that inability to know what it's like to empathize immediately, is what causes people to react to things in a negative way... So I don't think it's unnatural or that it's bad for people to have that kind of reaction, it's hard to overcome.

Telling his parents about his therapy could have resulted in a heated argument. How would this benefit him? He had to take care of himself, so he could not simply defer to their opinion about therapy. How did he resolve this conflict? Ben was able to resolve

this conflict by acknowledging that their views are limited and based on what they felt to be true; and that their beliefs about therapy do not mean that they are necessarily correct.

Like Ben, Erica revealed her involvement to only some of her friends. Her guardedness and privacy was apparent throughout the interview particularly in her concerns about the handling of the data. In the following quote, Erica seemed concerned about this writer telling her family about her data.

All of this information stays confidential, right? Like, with some of the stuff, I am not even sure if my brother knows, so <I need to make sure that it stays private>... so I am wondering if my brother is going to find out. Will he?

It seemed important to Erica to have control over her therapy involvement, especially from her family, who may judge and criticize her actions.

Mental health is not that different from medicine. For many of the participants, the difference between seeking a professional consultation for medical issues and psychological distress seemed worlds apart. This was partly due to the cultural stigmas surrounding mental health and their limited exposure to mental health. For three of the participants (Connie, Erica, and Fran), visiting a psychologist's office for a consultation was no different than going to a medical doctor for a pain or ache. Connie made a comparison between going to a medical doctor to address a heart condition and consulting with a psychologist to address an emotional issue. In comparing mental health to physical health, she was able to recognize that therapy was a form of self-care and that the "dependency" often associated with therapy was no different than consulting for any other medical ailment. Erica also viewed therapy as no different from any other type of self-care activity, e.g., massages, yoga, and physical exercise. In deconstructing therapy

and re-conceptualizing it as a form of self-care, she saw that it was comparable to other “more acceptable” forms of self-care.

Advice from doctors and endorsement of family and friends. Several participants (Ben, Connie, Denise, Erica, and Gina) were introduced to the benefits of therapy by their medical doctors, family members, friends, and employers. The personal experience

The testimonies of close friends helped to reduce their stigmas of therapy in two main ways. Erica’s friends normalized her fears in going to therapy by talking about their own experiences and the ways that they improved by going. Their involvement normalized therapy and made it seem more approachable. Denise also stated that after her friends had shown her support and gave her a list of referrals to “good psychologists” in her area, she expressed more interest in participating. When her friends followed up with her to see if she had gone, it pushed her to at least try it out. To Denise, her friends’ insistence demonstrated that they were believed it would be beneficial to her wellbeing, and that it was out of care for her. It was all the motivation she needed to eventually schedule her first appointment.

It was helpful for Harold to listen to several of respected peers about their experiences in therapy. As he was getting through his internship program at his church, he was immersed in a therapy friendly environment and surrounded by Christians, like himself, who had received a tremendous benefit from therapy. This exposed him to the evidence that mental health was relevant in his life and that therapy was not simply relegated to the “intense cases” he would come across in passing. In the following quote, Harold talked about how this exposure shaped his views.

I met a lot of people, all of whom I really respected, who were getting counseling and learned about how it completely transformed their lives. I think because of that, people who I respected, my experiences dealing with my own discombobulated feelings of suffering and loss, depression to some degree... and meeting with people who were really struggling, and seeing the humanity in them. All of these experiences really opened and broadened my view of <therapy>.

As Harold's worldview began to shift and broaden, so did his views of mental health. Therapy was no longer for the "Schizophrenics" but anyone and everyone who was looking to develop and become more in touch with their selves. As Harold reflected on himself, he recognized the fact that "we all have issues." He continued his process group and continued to develop a deeper self-understanding.

While his interest in going to therapy was high, due to several life circumstances, such as availability and money, Harold decided to pursue it at another time when these would no longer be issues. He was also looking for a specific kind of psychologist who could relate to his ethnic and spiritual background. It was this challenge of finding such person that had deterred him from going into therapy in the past.

Harold's process in going to therapy was similar to Denise in that one of his best friends introduced him to a really good counselor. He has a tremendous amount of respect for this friend, and his words were not to be taken lightly. It was the strongest endorsement for therapy that he could receive. This friend was a mentor, someone who related to him as a Korean American. In the following quote, it was apparent that his friend's testimony was an important part of making his decision. Harold would later

schedule an appointment with this psychologist and develop a strong relationship with him via a therapy that would last for several years.

A Korean American friend, who was a really good friend of mine, became a member at our church in 2002 and he started going to see this guy named Ron... and he was so impacted by his sessions with Ron and because he was so impacted by his sessions, I was kind of like, 'Oh my goodness.' And <this good friend> would tell me, 'Dude, you should really go see <his friend's psychologist>.' And I would tell him that I'm already getting stuff on my own and he was like, 'No, no, no, you have got to see him. He's an exceptional therapist.' So, I was like, 'Sure, why not.'

The influencing power of a glowing testimony from a close friend could not be understated. After this conversation with his close friend, Harold could not think of a reason not to at least try therapy. He believed the impact that therapy had on his friend, without question.

Similarly, the weight of his doctor's opinion and recommendations were important to Ben as he considered his options. Several doctors, two of whom were personally related, had referred him to a psychiatrist and a psychologist for a consultation. Though he did not respond immediately, their words impacted him, as he took it upon himself to gather information and read about clinical psychology and psychological disorders. "It was a combination of doctors telling me that <I> should see <a psychologist> to help me with what <I'm> going through and reading up on <clinical psychology>. Because the recommendations were from reliable, reputable sources, it motivated him to read a couple books on clinical psychology. He learned about Major

Depressive Disorder, among other diagnosis, and wondered about the possibility of having this disorder. There was a sense of relief in knowing that there was an entire field devoted to psychological issues that may be able to explain his illness and instill hope for a life where he was less depressed, tired, and exhausted.

Family endorsements also played a significant role in encouraging Connie, Fran, and Gina to try out therapy. For instance, Connie talked about how her sister supported her throughout her most difficult times and acted as an intermediary to her parents, both crucial aspects that led to her involvement in therapy.

If my sister hadn't talked to me about it and made me feel like it was okay, I don't know if I would've ever brought it up. Because she made me feel like it was okay to bring <my need to be in therapy> up. Chances are, I may have brought it up eventually but I needed her to be a supporter and liaison to make me feel like I wasn't crazy. She was really instrumental.

Had it not been for her sister's support, there was little chance that Connie would have entered therapy. Because of the language barrier between Connie and her parents, it would have been difficult for her to explain her problem and her rationale for going into the treatment facility. Connie's sister reassured her parents, who reassured her that the cost of treatment was not an issue. In fact, her father was encouraging and supportive of her interest in seeking help because they, too, felt that her problem had spiraled out of control.

Fran's mother was a women's counselor, who promoted emotional growth and mental health in their household. Though she did not consult her mother prior to entering therapy, the positive impressions of it throughout her childhood planted a seed that later

reminded her to go into therapy when she was in a complicated and emotional situation that involved several of her friends.

Gina reported that her sibling had benefited from therapy in the past. Her parents had already seen the positive impact of therapy, without any of the negative repercussions associated with the cultural stigma. She stated, "...my opportunity to <go into therapy> actually had a lot to do with my youngest brother going to therapy when he was younger..." Her brother's positive testimony in therapy gave her the belief that she could sort out her problems by talking to a psychologist as well. Additionally, her parents were open to mental health services, which meant that she would not have to face their resistance or criticism in her decision-making. The following quote provides an example of her parents' willingness to seek outside supports via a mental health agency in a time of crisis. Gina reported that after she and her mother had a heated argument, during which she had expressed that there was no reason for her to live, her mother called a suicide hotline for assistance.

...she knocked on the door and it was her crying please talk to this woman on the phone and I was like why do I need to talk to this woman on the phone? And then somewhere in there I understood that this woman is on the phone because everyone thinks that I'm going to kill myself at this point, you know?

Her mother's openness to seeking outside support conveyed an acceptance towards mental health. Thus, despite her beliefs that her parents are strict authoritarians, Gina still felt comfortable enough to talk with her parents about going into therapy in high school.

Experiences talking through problems with family and/or friends. The majority of the participants were detached, private, and non-disclosing with many of their family

members. Some also reported being similarly detached in their friendships, or lack thereof. What differentiates these relationships from that inside the therapy room are not much, and it seemed that several of the participants were not accustomed to the style of verbal exchange and reflection that may be necessary for therapy to be beneficial.

However, there were several participants (Anna, Connie, Erica, Fran, and Gina) with friendships that have a quality that resembled that which was expected in therapy, e.g., a certain level of self-disclosure, a capacity to self-reflect, and some access to emotions.

These participants found comfort and relief in sharing their issues with a trusted friend. This type of emotional attachment between them and their friends could represent the framework for how they would relate to other people throughout their lives. If an individual has had relationships in the past where their needs were met, with whom they were able to find support and the ability to maintain an emotional balance, it could mean that he or she would have a greater capacity to trust and develop meaningful connections with others and to experience comfort and safety within relationships. For Fran, being vulnerable and talking about her personal issues with another person was not necessarily threatening or anxiety-provoking. Talking with a psychologist was not dissimilar from talking to one of her friends once she had developed rapport. There was no reason for her doubt that she could not develop a supportive relationship with her psychologist.

Anna also reported that she has had many friends who have helped her to deal with her personal problems and that it was not an issue for her to seek out the support of another person. When her mother passed away, Anna reported feeling alone and overwhelmed with grief and sadness. She needed her family, but they dealt with the loss in silence. As such, she turned to her friends.

When I'm feeling sad about my mom or when I'm feeling really sad or when I'm feeling really down, being able to vent that and to not feel like I can't feel that or that I need to get over and suck it up <is what I need>. My emotions growing up in the house have been invalidated, especially when my mom died. And so a huge part of my friends have been about getting their validation for my feelings, and my friends were able to do that, and my boyfriends have been able to do that. At different stages of my life, I've had different wants and needs and desires, and I've always had a way of building my own family, an extended family, with friends and boyfriends.

Anna's friends provided her a safe, non-judgmental space to talk about anything and everything that was on her mind. Such supports were instrumental particularly during their times of transition and change because they were able to meet her needs. They validated her feelings when she felt misunderstood, comforted her when she was lonely and feeling hurt, and gave her practical advice when she felt lost and directionless. In Anna words,

My friends were the ones that often helped me to get over my <emotional instability>, and even though I was paranoid I would tell my thoughts and tell them that it sounded crazy, and they would counter it. So I always had friends around.

These relationships laid the foundation for her impressions of a therapeutic relationship and expectations of the psychologist to support her. With the support of her friends, Anna overcame her addictions to drugs and redeveloped a healthy sense of reality when she was not able to do it on her own.

Her father was not only “negligent” and “unavailable,” but verbally and physically abusive. Adaptively, Anna surrounded herself with supportive friends and mentors who provided her a level of care and guidance that her father could not.

I’ve always been the type of person to seek out support if I needed it. It is my sign of resilience, my ability to seek help outside of my community... with school, with friends, with teachers, and with other adult figures.

Anna was not afraid to ask for advice or guidance from people who may be able to help her. She also has no issues with talking about her problems candidly and depending on others.

Like Anna and Fran, when Connie looked back on her childhood friendships, she talked about how important they were in managing her conflicts. After a heated argument with her parents, Connie would go to her friend’s houses to seek refuge. In Connie’s words,

My friends were really there for me. I had some really good friends who figured out what was going on and really picked me up... they were really there for me... they never judged me. They were just there for me, like, “What can we do for you?”

Not only did her friends meet her needs, they were responsive and available whenever Connie needed them. This type of reliable support was the basis for her confidence in building a trusting and open therapeutic relationship with a psychologist.

Erica and Gina also reported positive and supportive relationships, with whom they were able to comfortably share their emotions and receive support. As with the other participants, Erica and Gina’s friends were similarly emotionally supportive,

understanding, and helpful when they were distressed. Gina specifically described what she received from her conversations with friends. They helped her to “put the pieces” together and make sense out of her problem.

I think when I hear myself talk aloud... I want to speak for myself. A lot of times when I speak aloud about maybe something that wasn't quite right, as I say it out loud, I hear myself speaking... even if I say the same thing in my head, it's different. In hearing yourself talk, you can make connections to your past and realize other things that cannot be addressed simply by pondering it. Hindsight that you may not have been able to see before, because you were obsessing over a certain point in your mind, becomes clearer.

Gina was quick to admit that her emotions did not always make sense to her; especially when she was angry, she would react so strongly and uncontrollably that it would later surprise her. And, Gina saw the potential benefit of talking with a psychologist to sort out these emotions.

What is mental health? Who goes into therapy? Harold came into the process of therapy differently from most of the participants. As a part of his pastoral internship, he was required to participate in discussion groups aimed at developing an emotional self-awareness and an understanding of how his past relationships were informing some of the issues in his present relationships. His pastoral supervisor provided the venue and facilitated the group process, as he mentioned in the following quote.

We all started talking about some issues with spiritual maturity. We talked about our family of origins... and we would do these exercises, reflect beyond our family of origin and how they've affected us and how they affected the way we

live out today and how they affected the way we do conflict and it was during that year in these internship meetings that my eyes just kind of opened up...

Harold previously perceived the world through his narrow religious lens, in which the only thing important about life was following his God and reading the Bible. Mental and emotional health was contingent on his relationship with God, and a psychologist had no place taking on the role that was assigned to his God.

This group process challenged his perception of mental health. "Everything wasn't so black and white, or so cookie cutter and so easy." He was integrating psychological concepts in his faith, understanding persons through their family systems and reading scripture with humanity in his mind. He visited twelve step groups and witnessed the humanity of persons with mental illness. It was a radically different way for him to engage the world. I would visit some 12 step groups, and they were really influential. As he became more intrigued and captivated by this process, he was becoming more aware of how he related to others.

There are so many ways to understand me through my relationship with my father, issues with my family, anger and aggression, and conflict. Everything started coming to light... I was this young, know-it-all coming out of college; I thought that I understood God, theology, and all these other things. Then in 2001, while I was in New York, 9/11 happened. I was learning all this stuff about my family of origin and how it affected me today...

Harold discussed this process as an undoing of everything that he had known to be true. His distress and the other negative feelings that he had kept out of his awareness were beginning to come to light. In his words,

I started looking back at different moments of conflict that I had with people in our church community and it just came to me how I was lying about so much stuff in the conflict resolution... because I just didn't want to deal with conflict because of all these underlying issues of fear and anger and aggression.

Harold appreciated the analytical aspects of therapy as well as the self-understanding that he gained from his process group. It also exposed him to the therapeutic process and its benefits. His church community was one that supported therapy, with many of its leaders in therapy as a means to provide better counsel to the congregation. Knowing that staff has been a part of therapy had a normalizing effect on Harold's views of mental health. Everyone was a part of therapy, how could it have been seen as a stigma?

Harold and his peers were a part of this church subculture that promoted emotional health through therapy and counseling. If he had not joined this church, he would not have known to engage in these processes. In other words, this seed was planted through his church and cultivated by its congregation. Being in such a community made it easier to tolerate the uncertainty of therapy, its stigmas, and the potential social ramifications if his friends or family knew.

As stated earlier, the majority of the participant did not believe that therapy was relevant to their lives. Ben stated,

I had no idea what depression was, I really had no idea what mental health was, and the thing that makes me sad is that I thought everyone felt like this – waking up every morning not wanting to do anything, forcing myself to do stuff, thinking that all I wanted to at the end of the day was to take a nap... I thought that was just life.

When Ben learned how his issues were related to a psychiatric diagnosis, it gave him a framework from which to conceptualize his issues and the solutions to resolve them. The literature normalized his struggles in a diagnosis. It learned that his exhaustion may have been caused by something that was psychological in nature, and associated with changes in the neurochemical balance. Knowing that his exhaustion could have been explained by something that went beyond his own laziness was reassuring, and served to alleviate his guilt and sense of responsibility. Scientific knowledge provided a convincing reason that therapy may be able to ameliorate his issues. It also gave him the theoretical framework to understand mental health, conceptualize his issues, and work towards resolving them; in other words, mental health was beginning to make sense to him.

Ben also talked about the impact that media and pharmaceutical advertisements have had on his views of mental health. It was a disease as opposed to a characterological or genetic weakness. This was coupled with all of the conversations that Ben and his peers had about medication and therapy, and which of the two were beneficial to them.

All the jokes about Prozac were starting to die away as other things were starting to come out, like Zoloft. And I think finally people were realizing that it was a disease and more people were starting to talk about it. And I met people who would say, 'Yeah, I take Prozac.' And so my understanding of mental health was better when I was in college.

When his acquaintances and friends openly talked about their use and the function of psychopharmacological drugs and therapy, it helped him to form a perspective of mental health from that of a consumer who was of his age and stage in life. Testimonies that

spoke to the effectiveness of therapy from relatable and trustworthy persons enhanced the credibility of the endorsements tremendously.

When Ben was a medical student, he had the privilege of interacting with psychiatric patients on a rotation. The impact of this experience added another layer of context and personal meaning to this notion of mental illness. The patients he had referred to as “crazy” were also people with interests, ambitions, needs, and fears. In his words,

As I went into medical school and I started to interact with patients in my rotation in psychiatry, where we went into the inpatient ward at a public hospital. We interviewed, we did a mental health exam on a couple patients... I think that experience really upended my knowledge of mental health from being just an academic textbook knowledge to how it really affects people and my perception and attitude towards it changed a lot...your perception of your life is affected, and it's such a dramatically debilitating thing when the illness is affecting your perception of life. It's not just, 'Ow, that hurts.'

The human-to-human encounter with an individual with a mental illness allowed him to empathize and connect to the pains of that individual; and in doing so, he was able to access some areas in his personal life that could be addressed and dealt with in going to therapy.

Acculturation: Openness to mainstream culture. Therapy is a form of “treatment” founded on Western principles and sensibilities of health. The goal of some therapies is to help persons to develop an individuated sense of self, one who is emotionally integrated, secure, and well adjusted. These are typically qualities that

characterize a “mature adult” in Western societies. However, for traditional, highly enculturated Korean Americans, who may not identify with such Western characteristics, the utility of therapy may not be relevant.

The participants of this study were found to be fairly acculturated to the mainstream culture and preferred American choices in music, movies, and language. There was a split between those participants who preferred Korean American and non-Korean American friends as well as American and Korean cuisine. Many of their parents (Ben, Connie, Denise, Erica, Fran, Harold) maintained their indigenous cultural values, unless it was out of necessity – working in business often required their parents to demonstrate an interest in spending time and relating to their non-Korean partners and associates. With the smell of pickled cabbage (kimchi) and Asian spices, and the mandatory shoes-off policy, and the Korean styled furniture, it seemed clear that these participants’ parents were invested in maintaining their Korean culture.

Immigrant parents who embraced cultural diversity and the Western culture seemed to be more willing to novel experiences and fostered a curiosity in their children. Anna, Connie, and Fran reported that their parents were comparatively more “liberal” than most Korean American parents and accepting of apparent disparities between traditional Korean and Western values.

Fran’s parents were described as “open” and “willing to adapt” to the mainstream culture. This was evidenced by their fluency of the English language, their interests in American cuisine, entertainment, and media, and their many non-Korean American friends. In response to her placement in the English as a Second Language track in Elementary School, Fran’s parents decided that they would only speak English in their

household. They immersed themselves into White American communities because they believed it was necessary in adjusting to the U.S. They packed their child “American food” and washed her kimchee to accommodate her acculturated, American palette. In this way, her parents were open to meeting her needs.

I would do things like take a dance class or take a piano class and eventually I want to quit and my parents were almost too willing to let me stop, so it was kind of the opposite of what you would image a Korean parent being like.

Fran’s parents honored her interests, opinions, and feelings, which enabled her to develop a sense of individualism. If she wanted to pursue therapy, they were unlikely to dissuade her. Her parents were unlike her friend’s more traditional Korean American parents in that her dating partners could have been of any ethnicity and her career goals were not limited to professional, white collar careers.

My parents never pressured me to be a lawyer or doctor, and there was never anything like, “you have to marry a Korean American guy.” So, basically when it came to my marriage or my career, they were very open in whatever path I decided to. That being said, education is very important to them, so I had to go to a university... my parents were also much more strict than American parents because I had a strict curfew in high school, and knowing that there were things that I couldn’t do compared to my peers.

Rather than telling her that she had to be a doctor or a lawyer, her parents asked her about her career interests and tried to support her in achieving them. And, if she wanted to be in therapy, her parents would not have objected. Additionally, Fran was raised under the

mainstream American culture and encouraged to do as her White American peers did. Fran was unable to identify with her more traditional Korean American peers.

When Fran entered college, she made the conscious decision to live outside of her comfort zone and interact with people of all different ethnicities. She went to school in the heart of New York, and saw this as an opportunity to grow and meet new people. She disassociated from the usual Korean American social circles that she had been a part of in her hometown.

I made the active choice to not spend any time with one ethnic group. I wanted to be open to any kind of club or any kind of class, and not necessarily just one or to one group of people. So, when I got to college, I acted on this decision... it was really refreshing because I wanted to have the most active and eye-opening experience that I could while I was in college.

Fran participated in new activities that stretched her notions of the “normal experience.” She sought out “the new and the different.” She was deliberate about identifying herself as an “American,” as opposed to a “Korean American,” but decided later to acknowledge her Korean ancestry to honor their impact on her life. Without them, she would not exist. Thus, as a tribute to her ancestors, she considered her ethnicity, “American of Korean descent.” The following quote details her thought process.

I didn't feel comfortable identifying as Korean American because I never felt that I was Korean enough compared to other Korean Americans I knew and had classes with. At the same time I know myself, and I know certain Korean manners like taking off my shoes when I come home, and I enjoy eating Korean food, both

of which are things that not your typical American household does... hence, the phrase that identifies me as “American of Korean descent.”

This title symbolized her detachment from the traditional Korean culture, which was also reflected by her responses to the acculturation scale. On it, Fran did not express any particular liking or interest in the Korean culture; she identified herself as American, not Korean, though that was not an indication that she disliked the Korean culture, either. She has an appreciation for the uniqueness of all cultures and diversity.

The other participants were also willing to go beyond their comfort zones to engage in novel experiences. Like Fran, Anna was also raised by parents who also embraced the mainstream American culture. Her mother wanted her to have a diverse set of experiences unlike her in her youth. She encouraged Anna to join a variety of opportunities – youth sports leagues, girl scouts, and after school activities. These opportunities allowed her the chance to befriend non-Korean American children.

My mother wanted me to be more ‘acculturated.’ When I talk to the Koreans, I found that I was more into sports and involved in the recreation center within the city, but I also went to a Saturday Korean school and was a part of my church and did the whole Korean thing, but my mom also let me play contact sports.

While her Korean American friends were socializing exclusively within their Korean American social circles, Anna was playing in individualistic sports, like softball, and learning how to articulate and assert her arguments as a member of both speech and debate teams. Though her parents pushed her to stay involved in Korean traditions and adhere to its values, it seemed equally important to her parents that she adopted the mainstream culture and immersed herself in a multitude of non-Korean activities. Her

parents placed her in a predominantly White American grade school; and as the only Korean American at her school, this participant quickly assimilated with her American peers. She learned to be more expressive around her peers; and she relied on her teachers and coaches for guidance as they supported her parents when her parents were unavailable. In the following paragraph, she elaborated on these unique opportunities that allowed her to assimilate into the mainstream culture.

My girlfriends at church couldn't because their parents didn't want them to get hurt and they felt like academics were more important, so I got to play softball and things like that, which was different. When I think about the academics I did in school, I think about speech competitions. She wanted us to speak Korean and stuff but she also allowed us to speak English to her, and she had a lot of American friends because she was a nurse... and she spoke English well.

Like Fran, Anna was able to find her own voice and pursue her interests. Compared to some other participants, who were from more traditional backgrounds, Anna was not as concerned with how other people would respond to her actions. In her mind, they could think whatever they wanted, but their opinions would not change her mind. Anna was assertive about getting her needs met, even if it meant that other people would have strong negative reactions.

Overcoming logistical obstacles. Logistical issues presented serious obstacles for several of the participants (Connie, Denise, Harold). Cost was an issue for individuals who did not have the benefits of a health insurance plan. Any logistical inconvenience could potentially deter an individual from going to therapy.

Gina and Harold did not have the benefits of a college student, and Connie's needs were greater than what the college counseling center was able to provide her. Each of their therapies was relatively pricey and costly, in that it had to be scheduled around their work and school schedules. The lack of availability of suitable services, limited finances, and the emotional investment required of clients in therapy were all logistical reasons not to participate. Additionally, for Connie, who researched inpatient rehabilitation treatment centers via the Internet, she put in countless hours calling clinics and speaking to representatives in looking for the best service for her. In her words,

So, everything had to work out for me in terms of finding a facility that had an opening for me, that it was an eating disorder house, and they had some of their program materials online, so I could take a look and make a decision.

Looking for the best site for Connie required long hours of research and initiative in calling and getting information on their availability and a description of their program and facilities. One of the challenges was sorting out all of the sites that were out of her financial range and schedule. A welcoming aspect of her research was the helpfulness of the people she talked to as they were kind enough to refer her to other quality facilities that were within her price range.

Initially, Connie's limited availability and specific needs presented a huge challenge in finding a treatment center. She had to cold-called a long list of facilities and organized a list of sites by their availability, monthly fees, and programming, all of which was used to make her decision. Through her persistence, she was able to find the "perfect facility" for her.

Timing and stage in life. It was not a coincidence that the majority of the participants entered therapy as college students. For several of the participants (Anna, Ben, Connie, Denise, and Erica), timing was an important factor in entering therapy. As mentioned earlier, the most opportune time for therapy seemed to be the college years, when there was an opportunity to live on one's own. All but two of the participants (Gina and Harold) first thought of going into therapy while they were college students. All but one of the participants (Fran) stated that their parents were a part of their decision, even if it was only indirectly.

As Ben was weighing the pros and cons of therapy, he determined that it could not benefit him for his parents to know; he went on to say that it would have only created problems and an unnecessary, tiresome conversation with his parents about a personal decision that did not involve them. For Ben, "good timing" meant that he needed to have a sense of privacy and the agency to make his own decisions, without the need to adhere to his family members' opinions. Having this separation from his family was instrumental and necessary in going to therapy. Living under their roof would not allow him the privacy to go to his weekly therapy appointments without his parents knowing. In his words,

If I was living with my family and going to therapy, there was no way that I could have kept it private... are the pros of therapy are going to outweigh the fact that my parents are going to be worried? It didn't, so I didn't do it.

Ben elected to manage his problems on his own than to reveal his therapy involvement to his parents. As such, he developed other ways of coping with his tiredness and his distress, such as origami, reading, and other distracting activities. Once he was living on

his own, and safely compartmentalizing his therapy life from his family, Ben went ahead to schedule his first appointment.

Connie determined that “good timing” was any time that overlapped with the availability on her schedule. Given her selective interest in an inpatient residential treatment facility, timing could have been a huge limitation. Of the affordable sites she had on her list, one had to have availability during the summer.

Time was a big thing and continues to be a big thing. I don’t know why I focus on money so much. To me, I never want to waste money. I still think, “Do I really need to waste money to talk to someone?”

Because she did not believe that a weekly therapy session for 45 minutes would have much of an effect on her 6-hour daily workout routine, this was not an option. Given the severity of her condition, it was “all-or-nothing,” as Connie articulated. If she could not find a residential treatment facility that had availability for a month during the summer, she would have had to figure out another way to get through her issues and possibly suffered through her mental illness. As it turned out, after spending countless hours researching sites, Connie found a site and enlisted in the program as soon as she received the financial support of her parents. Persistence paid off.

Last alternative. The majority of the participants (Anna, Ben, Connie, Denise, Erica, and Gina) viewed therapy as the “last line of defense.” That is, if therapy did not help them, and their symptoms persisted, then there were no other options left for them; at the extreme, they would be resigned to living the rest of their lives with their mental illnesses. For Connie, this was a difficult idea to swallow, so much so that she reported living in denial of her mental illness for several years, believing that when the time was

right, she could control her issues and move forward with her life. Connie believed with all of her heart that therapy was unnecessary. She was months away from graduating from an Ivy League School with a promising career in fashion merchandising as a buyer for a high profile department store; and the pressures to cut down her exercising and binge eating came to the forefront. Connie tried to manage her problems in a variety of ways, but her symptoms persisted. She couldn't control herself. Therapy was a "now or never," "life or death" type of option that she was forced to confront. It was the final option that determined whether she would have to live her life this way until the end, or not. In this moment, Connie decided that she needed treatment.

In such dire circumstances, there were not that many options left. In another example, Anna tried to manage her anxiety on her own through substance abuse; and before she knew it, she had two unmanageable problems, e.g., an anxiety disorder and substance dependence. After several months of experiencing visual hallucinations, Anna's fears of becoming "permanently crazy" motivated her to eventually seek out professional support. She had reached her breaking point. Her internal and external resources were no longer helping her to cope with her psychological issues, and she was in an incredible amount of distress. In the past, she would have the support of her high school friends or a boyfriend to help her through these times. Anna stated, "I always had one stable figure in my life, usually a boyfriend. And I had a best friend... I had very good friends. I can say that these friends have carried me throughout my life." While she was in college, her close friends were no longer in her day-to-day life. This was combined with entering a highly competitive environment, which brought about a level of anxiety in her that she had never felt in her life. She also moved to a new city, away

from all that was familiar, and in a three year relationship that had just turned long-distance. Needless to say, she had a lot of her mind, and her usual reliance on her friends to cope with the stress was likely to insufficient as she “fell apart” in her first year.

Anna had to develop new method of dealing with her stress. She found out that therapy and drug counseling were offered at the counseling center on campus, and was immediately drawn to it. After trying a variety of treatment options, all of which failed to help, Anna was desperate and, as stated earlier, she has always had to be proactive, resourceful, and very willing to seek out the support of others.

Chapter 5

SUMMARY AND DISCUSSION

Summary and Discussion of the Findings

This chapter summarizes the thematic findings in relation to the research objective. This study examined the decision making processes of eight Korean Americans as they were considering the option to enter therapy. This section begins with a summary of the thematic findings related to the three research questions: 1) how participants were introduced to therapy; 2) their obstacles in entering therapy; and 3) their process in resolving these obstacles to eventually enter therapy.

Introduction to therapy. Many of the participants were introduced to therapy during a period in their lives when they were suffering from significant psychological distress, so much so that they were desperately looking at all types of supports. Significant changes within their environments, e.g., entering college, living apart from their families and friends, and starting a new life, were overwhelmingly stressful. Some of the participants reported that their friends tried to help but were unable to take care of them. Some of these friends then introduced therapy and recommended for them to meet with a psychologist. Academic pressures also motivated several of the participants to consider services at their college counseling centers to address the reasons why they were not able to study efficiently.

Obstacles to entering therapy. All of the participants, to some degree, were raised to follow certain Korean traditions, whether it was eating Korean food, taking off their shoes inside their homes, or speaking Korean. Korean Americans have specific mechanisms via social institutions, such as the church, that allow for the preservation and

practice of traditional Korean values. Assimilation to the mainstream culture becomes an unnecessary component of living in the U.S. as the most basic needs can be met through this community or someone within it to assist them. This allowed for many Korean immigrant families to maintain a high level of enculturation (e.g., the extent to which an individual retains the cultural values and traditions from their country of origin), which was a consistent theme through all of the participants' narratives.

Traditional Korean parents may expect their child to defer to their advice, or be criticized and shamed for acting like a disobedient and obstinate child. Any child living under such circumstances would understandably choose to obey their parents rather than to make choices on their own, unbridled by the often harsh opinions of their parents or peers. All but one participant expressed a concern that their parents' reaction, and preferred to persist in their psychological illness for additional time and avoid a potential argument. This was not the appropriate environment for children to challenge their parents' requests, or to make decisions based one's personal convictions. It seemed to be one based on a hierarchical structure of power, where individuals with the most years of life experiences were assumed to have the answers.

The psychological basis of conceptualizing and treating an individual is based on Western sensibilities of development and health. Individualism, one of such concepts, postulates that individuals are within their right and responsibility, and perhaps a moral imperative, to become separate and autonomous and in control of their self. For example, a child raised in such an individualistically oriented environment is socialized to leave their parents' homes, to find their own way religiously and ideologically, and to follow their passions. Entering therapy for such an individual may be understood as an

individualized choice to do what he deems necessary to address a personal issue. Such a person may consider his family and/or friends, but does not allow it to overwhelm their decision making process. On the other hand, a collectivistically oriented child is drawn to act in accordance to the harmony of relationships. He is sensitive to the situational context and likely to base a part of his decision on the negative consequences it may have on others. Thus, even if an individual was experiencing distress, if seeking therapy was not in the best interest of the collective, it was discouraged from being pursued.

Misinformation about the processes in therapy was an obvious barrier among immigrant populations, and among the Korean Americans in this study due to their stigmatized view of mental health. Traditional Korean immigrants are more likely to believe that therapy is best suited for persons with severe mental illness, e.g., psychosis. Several of the participants had believed that therapy was suited for the most unstable individuals and “schizophrenics.” They were not able to identify with these individuals, nor did they want to be classified. There were few, if any, persons associated with mental health with whom they could relate. Without any public Korean Americans advocating for mental health, there was a conceptual distance between what several of the participants had believed about therapy, e.g., a service for non-Korean Americans, and what it really was.

Several participants described a “supportive” relationship as one which involved their parents or a friend giving advice on how they should take care of their issues. This “advice” typically was not offered because they were asking for it, but because the tension that had escalated from their issue was causing undue distress onto others, and thus needed to be handled promptly. It was as much their issue as it was their parents,

which pointed to collectivistic nature of their relationships. This type of reaction had caused several participants to turn away from others in times of distress. It also informed their impressions of how a psychologist would handle them when they imagined the first therapy session. Would the psychologist ignore his concerns and provide ineffectual “advice,” as his family members had, and cause him to leave the session more frustrated than he initially was? The questions of the psychologist’s ability to accurately understand their problem and to respond sensitively and with care were two common themes that emerged in the participants’ narratives. Such parents were described by said participants as judgmental, rigid, and unyielding, so much so that it was less taxing to follow their parents’ suggestions than to engage them in an argument by asserting their own.

Processes in entering therapy. There were several common factors that led the majority of the participants into therapy. Most of the participants reported that they had previously relied on several supportive friends, whom they had always turned to in problematic situations. These friends appreciated their quirks, validated their senses of agency to make autonomous, independent decisions, and supported them through it all. Several participants reported that they would often talk to their friends late into the night after a heated argument with their parents or take refuge at their homes for nights. Traditional Korean immigrants may not have been as emboldened to escape to their friend’s homes for support, let alone talk to them about their issues, as disclosures outside of the home may be strongly discouraged and viewed as an act of betrayal against the family.

These relationships fostered their abilities to seek out support and talk about their personal problems, both qualities which were not encouraged within their traditional

Korean households. However, the participants interviewed in this study were different from their less acculturated parents, in that they believed in making decisions based on their personal interests and needs. Their diverse groups of friends also contributed to fostering this sense of individualism and independence. Having a strong supportive network outside of their home was particularly important in creating space between their opinions and the influences of their family.

Because the boundaries between the self and other tended to be permeable and diffuse among traditional Korean family members, having a sense of autonomy from their family was difficult for several of the participants. Participants who lived further apart from their parents were naturally better able to define these boundaries and were found to be freer to making their own life choices. This psychological distance from their parents allowed for the opportunity to explore themselves – their needs, interests, and desires – without the undue pressures to conform and defer to their parents' expectations. As persons with defined boundaries, these participants' self-esteem were not constructed around the attaining the approval of their family members or by fulfilling their demands and expectations. For a collectivistically oriented person, the opinions and potential reactions of others matter.

Challenging the authority of one's parents is viewed as disrespect. When a person acts on his own volition, without considering others, his actions can be interpreted as selfish and self-centered, which is both threatening and offensive to the family. That said, a couple of the study participants reported that they fought back when their parents disagreed and stood firmly in the face of their pressure. They described themselves as "brash" and "insolent" compared to their "well-behaved" Korean American friends; and,

they may have been, but they were carving out their own, much akin to the individualism encouraged by the Western culture. This assertive quality was a common thread in each of the narratives. This emerged for many of the participants as college students. The child was beginning to respond to his environment by himself and learning how to make decisions that he deemed were appropriately in his best interests.

Immersing oneself in a “therapy-friendly” city like Manhattan, New York typically has a similar, normalizing effect. Korean Americans may be more willing to see beyond the culturally based stigma of mental health if their social networks valued it. Several participants told a select few that they were thinking about entering therapy. Whether it involved listening to a friend’s personal testimony about his gains in therapy or partnering with a friend with an interest in therapy and planning a first therapy appointment, social acceptance was a powerful agent in normalizing the stigmas of mental health. Two participants were compelled to follow through with their friends’ psychologist referrals; one, after a trusted friend gave him compelling testimony, and the other, after they had pleaded with her to get some help.

When a person discloses a deeply personal issue from the past and how he needed therapy to get through it, it can have a sobering and disarming effect on the listener. Such candidness was relatable to several of the participants who were able to share their own issues in detail. Sharing such sensitive and vulnerable material can seem threatening, especially because they had been harshly criticized or dismissed in the past for talking about such “weaknesses.” Emerging from these discussions was “being honest” with oneself and presenting the more real self to others. It was “freeing” to listen to their inner-voice and to act on their own accord and interests. The value of simply being and

allowing one's self to emerge freely and openly was a process that started to occur. Rather than conforming to the cultural expectations of being a "good person" and presenting oneself as such, they were empowered to take ownership of their lives. In the context of this study, if they believed therapy would be helpful to their overall health, then they were behooved to try it. The judgment and criticisms that they had heard about mental health became less relevant in their lives.

The findings from this study indicated that Korean Americans were more likely to consider any form of treatment, including therapy, once their psychological and emotional issues slowed down and impaired their daily productivity and academic performance. Several of the Korean Americans in this study hoped that therapy would help them to improve their grades. The academic pressures to succeed were highly stressful for several participants, whose parents expected nothing less than an A on their report cards. Other participants reported that their problems were too complicated to talk about with friends; what they needed was the expertise of a professional.

There were certain persons who entered therapy only after they have exhausted all of their internal resources and their problems have reached an unmanageable point. This tendency to seek help in the worst case scenario speaks to the culturally based expectations of stress management. For many Korean Americans, who had ineffectually relied on their self-determination and perseverance to overcome their problems, the idea of voluntarily entering into a therapeutic relationship seemed threatening and shameful. One of the participants exclaimed that her parents expected her to "have it all figured out!" A common sentiment among Korean American parents to their children, what this

conveyed was that 1) no one would help her to solve her issues and 2) talking about her issues was a sign of weakness, a threat to her self-esteem and self-worth.

Some participants were introduced to therapy by concerned friends, who had reached the end of their line and did not know how to support them any further; a counselor at their college who had met them in front of a booth for mental health awareness week; or via a pamphlet at the dorms or the Internet homepage of the college counseling center. Several reported taking a “shot in the dark” and entering therapy cautiously, with the intent to discontinue after the first session.

Many of the participants straddled two different worlds between their traditional Korean home environments and their mainstream American lives with their friends and peers. While they faced a tremendous pressure to excel at school, they also had the latitude to assert their choices and pursue their individualized interests. The majority of participants indicated that they were more engaged with the mainstream culture and endorsed higher levels of acculturation. The results from the Suinn-Lew Asian American Acculturation indicated that each of the participants were classified as bicultural or Western-identified, which suggested that they were relatively acculturated. They were not necessarily against the idea of therapy, and had a larger issue with the negative reactions that they would receive from their family and friends. Thus, even if therapy would have benefited them, they would have rejected therapy if there was any doubt that other people could know.

Financial restraints, the inconveniences of travel, and the lack of availability may be challenges for many Korean Americans. Consistent with the research literature (Shin, Song, Kim, & Probst, 2005), the participants of this study reported that health insurance

and the affordability of services were critically important in their decision to go to therapy. The free services available to college students gave some participants an incentive to try therapy at the counseling center. Despite their meager financial means and time constraints, it was still possible for one participant to find a training clinic with a sliding scale. Cost and time were factors for individuals who were more ambivalent about their interests in therapy, as any excuse for them to avoid therapy would have been enough to reconsider.

Conclusion and Implications of the Study

As long as the culturally based social stigmas towards mental health and the costly social ramifications of entering therapy persist within Korean American communities, rates of mental health utilization are expected to remain low. Korean Americans, who are a part of communities that support therapy, are more likely to find it beneficial and relevant to their personal health. These persons tends to be more comfortable seeking and receiving support from another person and capable of expressing their thoughts and emotions clearly.

The purpose of this study was three-fold. First, this study intended to examine the contexts in which Korean Americans were introduced to therapy. Second, this study highlighted the specific barriers that Korean Americans encountered in their processes towards entering therapy. Lastly, this study was aimed at describing the process of overcoming these obstacles among Korean Americans. There are many pathways to entering a psychologist's office for a first appointment. This study sought to ask its participants how they moved beyond the stage of contemplation and ambivalence to contacting their psychologist.

Outreach to Korean Americans. Outreach to Korean Americans have been challenging, as it is no easy task to make a convincing case for therapy to any individual who does not recognize how it can be applicable to their lives. Making a case for therapy by presenting information about therapy, mental illness, and related cultural stigmas and conversing with Korean Americans may be effective for the Korean American who has relatively low scores on the enculturation index and high on the acculturation index. However, the majority of the Korean Americans, who are not as willing to accept therapy as a viable treatment for them, outreach of this nature may not relate to or overcome their dissonance towards mental health, particularly if those outreaching are not of Korean origin. There are several culturally based reasons why this type of psychoeducational outreach would not be effective with less acculturated Korean Americans who endorsed relatively high levels of enculturation.

If the content in the outreach is not relatable, then the Korean American is unlikely to hear and connect to its message. Understanding the subtleties and nuances of traditional Korean styles of communication as well as the slow developing yet lasting connections in their relationships, the effort demonstrated in relating to Korean Americans cannot be understated. Traditional Koreans may disengage from the outreaching individual, whose attempts to make an immediate and meaningful connection may be perceived with skepticism and suspicion. The agenda and forward message typically associated with outreach is likely to be interpreted as overly assertive, imposing, and controlling among Asian cultures, which places a greater emphasis on the nonverbal context than the symbolic representations and meanings of the words. Based on the relational concept, jeong, which governs the human relationships of many traditional

Koreans, trust is slow to develop and “incubated” over the course of time rather than actively and outwardly imposed. Thus, the presentation style of outreach may not an efficacious option in outreaching with Korean Americans.

Korean Americans may be more easily impressed by people with whom they are able to relate and better able to internalize the values and interests of members in their ingroups. It may be more important to enter the community and change its values from within. In this respect, community-based, systemic changes may allow for an opportunity to align with stakeholders and leaders within the Korean American community and provide a larger social impact. As the research literature has indicated, Korean Americans tend to congregate in social groups, of which may be based on their spiritual faiths, professional work, or social interests. This may present an opportunity to take part in such groups and begin to develop a relationship with its leaders, whose positions within their organizations command the respect and trust from their members.

The hierarchical structure and distribution of power in traditional Korean relationships operate under the assumption that age equates to wisdom, and that younger, less experienced peers were expected to follow the advice of their elders. Age is one of several measurements of status and power. Within this family, the child is expected to defer to the elder, which, in most instances, would be the parents; and, within the community context, this would be the spiritual leader. Thus, the potential impact of a spiritual leader or pastor over their congregation is as powerful as it is widespread.

One such example of a community-based outreach can involve a faith-based organization such as the Christian church, with the pastor who may lead hundreds and hundreds of other Korean Americans. Known in the Korean American literature for

providing an important support for recent immigrants, the Christian church has an extensive history of serving the Korean American community. Kim (2006) found that Korean American churchgoers' feelings of guilt and shame were mitigated through a relationship with God, a sense of belongingness within the church community, and faith practices.

There are several Korean American churches that are interested in developing a branch within their churches that pertains to the psychological and emotional health of their congregations. In a personal communication (2008) with a Korean American pastor of a predominantly Korean American church, his explanation for the lack of incorporation of mental health in the Korean American church is primarily due to the lack of "trustworthy professionals in the field," in that there are very few mental health professionals who are familiar with the Korean culture in addition to their Christian faith. Despite the apparent need and welcoming interest in mental health, the lack of compatible mental health professionals interested in this type of outreach continues to be a significant problem in the underutilization of mental health.

Limitations

Retrospective study. This was a retrospective study, one that asked its participants to reflect up to 10 years back in their lives. This presented an obvious challenge for older participants, who were likely to recall a more distant period in their lives and sift through the multitude of life events and changes; and this is only if they can remember what actually happened. It was immensely important for these individuals to suspend their present beliefs about mental health, as someone who has gone through therapy, and recall that period of their lives when they had a less refined and accurate

view of therapy. One of the participants (5) stated during the interview that she could not remember this time accurately and that this study may not have been appropriate for someone who has become so removed from her first experience in therapy.

Another significant issue in asking a participant to think back to a part of their history is that they may have changed significantly since this experience. That is, placing themselves back in that process could have been challenging because they were no longer that person five to ten years ago caught in this struggle. The participants' process of entering therapy may have been an issue that was overlooked and consciously thought through. It was also possible that their narratives were not entirely accurate, despite the participants' best intentions for the study.

Narratives delved into shameful parts of one's past. The stigma towards mental health still remains a very real phenomenon among Korean Americans. Traditional Korean communities may react to therapy and mental health with shame and scorn, particularly if one of their family members is participating. Individuals in such communities may have compartmentalized this aspect of their lives, as it was mentioned earlier, and may not have felt comfortable sharing it with anyone, even their psychologist. Yet, this is a study that requires such individuals to disclose their parts of their shameful past to another person.

Many of the participants also expressed a sense of discomfort sharing their personal lives, including their involvement in therapy, with another Korean American family member, friend, or peer. Yet, this study required them to overcome these struggles and share their intimate facts with another Korean American. It would not have been

surprising if a participant had a strong reaction to talking specifically with another Korean American.

The open-ended nature of the interview allowed for the participants to dictate the pace and content of the interview. This ultimately meant that it was the responsibility of the interviewer to foster a safe, empathic, and trusting environment where the participant can feel free to share whatever is on their mind. This style of data collecting presented one major problem. Hypothetically, if participants were so inclined to avoid talking about a certain point, it was in their right to do so. Sometimes, the conversational and open-ended format of the interview can place pressure on the participant to provide the perfect response, even after being told that there was not one. Ultimately, this style of interview requires a mutual trust between the interviewer and the participant. Sometimes, the issue of confidentiality was such a concern for the participant that an open-ended conversation was not possible.

Concerns about confidentiality. The participants' concerns about confidentiality were unavoidable due to the recruitment process. Every participant was between one to two degrees apart from the interviewer. This means that the interviewer either has a relationship with the individual who referred the participant to the study or with the actual participant. Erica was particularly concerned about where the information from the interview would go after the study was completed and appeared to suggest a level of distrust in the interviewer's capacity to keep from disclosing her personal information from the person who referred her to this study. There were three instances during the interview in which she expressed her reservations and concerns, albeit jokingly, that she would not want her brother to know about how she began therapy. "I'm wondering if my

brother is going to find out.” Her concern was evidenced throughout the interview in frequent pauses, short answers, and vague answers about her reasons for entering therapy.

Even though the participant was reassured that their narratives would be handled with the care and that their family and friends would not be privy to their personal information, it did not mitigate these concerns as their responses appeared guarded and controlled. This was a particular concern for participants (Anna, Ben, Erica, Gina, and Harold) whose family and friends did not know the extent of their psychological distress as well as their reasons for entering therapy. This interviewer may have been viewed as an extension of the family member or friend who referred them to this study; because they did not feel comfortable sharing their private details with them, it would be equally challenging for these participants to share it with this interviewer.

In the interview, participants were asked to talk about a deeply personal aspect of their lives – their reasons for going into therapy. As discussed in an earlier section, disclosing personal weaknesses may be criticized and looked down upon among traditional Korean Americans. For some participants (Ben, Denise, and Erica), telling their family members or friends about their involvement in therapy was still a conversation topic that was better left unaddressed from their point of view. This was evident among the participants who have not talked about their involvement in therapy with certain friends and family for fear of their judgment or a negative confrontation. Sharing such pieces of information can be challenging even to one’s friends. Facilitating an open dialogue would have been an effective approach to interviewing the participants had they been comfortable in talking about whatever came to their minds. However, throughout the interview, the majority of the participants (Anna, Ben, Connie, Erica, and

Fran) frequently asked this interviewer if what they were talking about was in the “right direction.”

During the interview, Erica appeared to have no memory of why she went into therapy. Couple this with her questions about confidentiality and her apparent discomfort in talking to a “friend of her brother,” it is understandable and entirely possible that she did not feel completely comfortable disclosing personal information. So, there are several possible reasons why it was difficult for this participant to talk about her process of entering therapy. It very likely was in part attributed to the amount of time that had passed since then, and the uncertainty of talking about her experiences with the interviewer and the fear of being judged.

Not representative of all Korean Americans. Due to the nature of the study, its sample size is small and not a representative group of all Korean Americans who have been in therapy. This sample profile was intended to reflect a subgroup of Korean Americans between 25 and 35 years of age; who have lived in the U.S. for the majority, if not all, of their lives; and who have completed or may be in the process of completing a college or graduate degree. Their levels of familiarity with the mainstream culture and their adherence to traditional Korean values were likely to be different within the sample.

Recruitment. Identifying Korean Americans who were willing to talk about their experiences in therapy came with obvious challenges. Based on my findings, there were few Korean Americans who have participated in therapy. There were even fewer Korean Americans who were willing to admit that they have been in therapy. And within this small group of Korean Americans was the sample that participated in this study. Thus, it is possible that the recruitment process actually whittled down the sample size to a

particular type of Korean American, who was interested in championing causes and building an awareness of mental health in the community. It is highly possible that this is a passion that not all Korean Americans share.

The majority of the participants (Erica and Gina) stated that they were very willing to be a part of this study because they recognized the lack of mental health awareness among the Korean American community and the important need for more effective outreach efforts. These participants have a history of learning about Korean American causes and then taking it upon themselves to educate others. Before Erica was able to teach others, she first had to teach herself. "I had to go and learn a lot of things by myself. I had to learn X, Y, and Z <all on my own>, and then teach my siblings, but there was no one there to teach me." Her unique experiences as an older sister to two other siblings provided her the empathy to relate to persons who were left to manage their psychological issues all by themselves, without hope for healing, and to mobilize supportive resources to meet their needs. Unsurprisingly, this participant was also involved in spearheading advocacy groups for Asian Americans.

One of the participants, who dropped out of this study immediately after he scheduled an appointment for the initial interview, expressed a concern that admitting his involvement in therapy would jeopardize his prospects of finding a new job as a lawyer. Though this participant seemed highly interested in the study and willing to contribute to the findings, when this writer called him for the interview, he was no longer interested. It seemed to this writer that the level of openness required of the participants in this study was too much for him.

Recommendations for Future Research

Future studies would benefit from a tighter set of exclusionary criteria in order to select individuals who were able to provide a narrative of their lives before therapy. This would result in more participants providing a narrative that is accurate, meaningful, and pertinent to the aims of the study. With that said, it is important to note that the drawback of having more astringent exclusionary criteria is the tremendous challenge of finding and recruiting the participants who match it.

One way to overcome this challenge is to develop partnerships with psychological clinics that cater to a Korean American population. Research can be built into their patient services, where all eligible clients are presented with the research study and invited to participate. And because the clients are ideally coming in for services regularly, it will not be as much of an inconvenience for the participant. Developing future research studies through collaborations with clinics are also of great benefit because the clinic provides all of the participants for the study. What this means is that the interviewer is not likely to know any of the participants on a personal level, or know of people who know the participants on a personal level. This can be helpful in that the participant may feel less concerned about their private information circulating among their social circles. Because clients are identified as eligible for this study upon the intake session, lengthy period from the participant's first session should not be an issue. Barring any cognitive limitations, participants should not have as much difficulty recalling their decision making process as they considered therapy.

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Table 1.

Love versus Jeong (L. Kim, 1996)

<i>Love (Western)</i>	<i>Jeong (Korean)</i>
More direct and overt expression	More indirect and subtle in emotional expression
More physical, behavioral, “chemistry” oriented	More affective, attitudinal, less verbal
More action-oriented	Silent, waiting, more inward, more thinking of, and wishing
Active, positive, forward, outward	More naturally and slowly developing
More need/desire-related	Incubation period needed, and not fall-in-love at first sight
More conditional, more contractual	More unconditional, less contractual
More intentional, volitional	More security and basic survival-oriented
Can be mercurial	Deeper, and longer lasting
Tends to be possessive	More connectedness and bonding-based
Tends to be competitive	More relational, trusting, and sacrificial
Tends to “conquer”	More caring and protective of each other
Differentiated boundary	Less differentiated, less boundary (more “we”-oriented)
Separated self (“I”-oriented)	More fused and merged
Happiness, joy, pleasure	More warmth and bliss

Appendix A

INTERVIEW TEMPLATE AND GUIDELINES

PRETHERAPY EXPERIENCE

This topic examines the nature of the participant's condition.

Considerations for the researcher are as follows: was there been an acute or long-standing problem that the participant had been hoping to resolve? What was the nature of the precipitant, or series of precipitants, prior to the participant's admission into therapy? For example, "I couldn't do day-to-day things" or "manage my schoolwork." "I had too many thoughts about... that hindered me from doing what I wanted." What the researcher is looking for are the factors that lead to therapy and the participant's understanding of how the option of going into therapy entered their mind.

FAMILY HISTORY

This topic examines what, if any, factors in the participants' relationships with their parents influenced their decision to enter mental health. Could the participants' families have impacted their decision to go into therapy? Could Korean American parents shelter their children from Western ideologies of mental health? Both are possible, but not necessarily a part of the Korean American culture. Political ideologies and philosophies may influence the likelihood of a Korean American individual who goes into therapy willingly.

Family members, both immediate and distant, may have been influencing factors if they have experience or an affiliation with mental health services. So, the researcher should be sensitive to the emergence of such themes. Questions include, "Did your family members go through therapy?" "What types of conversations did you have with your sister regarding her therapeutic experiences?" "How did it change your views of therapy?" "Is your sister/brother affiliated with mental health?" "Did you have any conversations with your sister/brother regarding their mental health experiences? Would you have felt any differently had your sister/brother (not) been affiliated with mental health? Family member's positive experience with therapy (not anyone else's) had enormous impression – "end result is that she's much better."

A discussion about the family members can also examine how conflicts were handled in the family. The researcher should consider how the participants' families handled intense and distressing emotions and how

they handled stressful situations. Additionally, in discussing this topic, it would be interesting to note what types of outlets or releases the participant and his or her family had during this period. Is this person a family member, or a friend, or someone else? And how is this person utilized? For instance, a question I may ask is, “Imagine your childhood -- what types of issues could you bring up to a therapist?” Were there things that you couldn’t talk about with someone outside of the family?

SOCIAL HISTORY

Talking to a stranger about personal issues can be easier for some people. For some, a detached relationship, one in which the other is not associated with his or her social circles, can alleviate the pressures of withholding. For others, talking to a stranger about problems can result in more negative ramifications. The researcher should be sensitive to themes of expression and communication styles. Is sharing difficult issues with their closest friends and family members yield comfort and support? In what way are they able to share what’s on their mind with their friends? Or do they prefer to keep it to themselves? Why? And does the participant have support that they can rely upon? Has the participant ever felt like sharing a private concern or problem with someone?

What did you consider the breaking point in your life? What was different about this breaking point from others when you didn’t seek out therapy?

ACCULTURATION RATINGS

Scale of 1 to 5:

1. Should consider the needs of others before themselves
2. Should not make waves
3. Should think about the social group over themselves
4. Needs to follow the role expectations of the family
5. Should be in control of one’s emotions at all times
6. Should have sufficient inner resources to resolve emotional problems
7. Needs to achieve academically to make one’s parents proud
8. Must focus all of his or her energies on studies

9. Children should not place their parents in retirement homes
10. Worst thing one can do is to bring disgrace unto one's family
11. One should be discouraged from talking about one's accomplishments
12. One should be humble and modest
13. How fluent are the parents in speaking English?

THERAPY EXPERIENCE

1. How many psychologists have you met?
2. When was your first visit to a psychologist? How old were you?
3. Where was the psychologist located and practicing? Therapeutic setting?
4. What type of setting, e.g. out-patient hospital, in-patient hospital, out-patient clinic, family center?
5. Who referred you to a psychologist?

WHY THERAPY

1. **Can you tell me a little bit about yourself and what brought you in for treatment?**

If the patient asks what the interviewer means by “tell me about yourself,” clarify, “*Like who you are, what you do, what you're like as a person, and who the important people in your life are.*” The goal is to get a sense of who the person is, how s/he views him/herself, current adaptive functioning, and his/her broader social context. Note that the goal here is also to help the patient feel comfortable with the interview and interviewer.

The interviewer should also inquire here about *treatment history* and *family history of psychiatric disorders*, beginning with a simple probe such as, “Has anyone in your family—mother, father, aunts, uncles—had psychological problems?”

It is also possible to begin by asking, “**Could you tell me a little bit about yourself,**” followed by, “**Are there things that worry you, are**

often on your mind, or that you struggle with?” and “Have you ever had problems with depression or anxiety? How about trouble with alcohol or drugs, or trouble with the law?” (Ask about eating problems if doing so seems appropriate here.)

“Are there interpersonal situations or relationships—like with friends, bosses, or romantic relationships—where you often find yourself running into trouble?” (The same questions may be useful with psychiatric patients, particularly those who do not readily admit their symptoms.) If the patient has completed a self-report screening inventory, the interviewer should inquire here about any items endorsed and their history.

TREATMENT BARRIERS

2. **Can you tell me about your understanding of mental illness prior to your first session?** (*Cognitive barriers*)

Specifically, the issues that constitute “mental illness,” the patient’s impressions of people with mental illness, and his or her understanding of how therapy can be helpful to them.

3. **Did you have any concerns about therapy prior to your first session?** (*Affective barriers*)

The patient may speak in generalities here. Redirect the patient to talk about specific instances that s/he imagined would happen during their visit to therapy, including thoughts and feelings, and his or her outcome of treatment.

Additionally, would the patient’s family, friends, or acquaintances perceive him/her differently? Did the patient have any doubts that therapy may not be helpful or that it may be more harmful than beneficial, or any feelings or thoughts toward his or herself about entering therapy?

4. **Can you tell me about your relationship with your therapist?**

If patient has a therapist, elicit treatment history, including present treatment, and ask for *one or two vignettes* of current and past therapists.

There are many reasons why people would not seek out psychological services. I’m interested in learning more about your own reservations to therapy.

5. *Cognitive Barriers – e.g. thinking that symptoms would improve on its own*

Certain beliefs and views of mental health and therapy can deter one from seeking psychological services. My next questions will refer to your thoughts about psychology, mental health, and emotional issues.

What do you think constitutes a mental health issue, a mental health disorder?

What types of psychological issues are addressed in therapy? Did these thoughts make it difficult for you to consider therapy?

Did you believe that other services could have helped you to cope more effectively with your issues? What types of services?

Now I'm going to list some common misconceptions of therapy. Let me know if you had any of these thoughts in entering therapy?

- Mental and emotional problems get better by themselves.
- Mental and emotional problems should be handled on your own.
- Therapy probably won't do me any good.

The goal of this question is to understand how the patient came to this understanding, be it of cultural or familial origins, and their convictions in these beliefs.

6. *Affective Barriers – e.g. stigma of mental health, shame*

Visiting a psychologist can evoke emotional reactions in some people. Such perceptions can be extremely stressful to someone who strives to maintain harmonious relationships with others. It may be preferred for such an individual to act in a way that allows him to avoid these perceptions from others. The goals of this section are to understand 1) the extent to which the participant considered the perceptions of others and 2) whether their decision was influenced by their perceptions.

How did you think people feel about seeking professional help? Was this a concern for you in seeking therapy?

Here is a list of common feelings people have about therapy. Have you felt any of these feelings in seeking therapy?

- Shame
- Disappointment
- Embarrassment

- Guilty
- Fear

Help me understand where these feelings were coming from. Sometimes these feelings originate from an incident, person, or cultural values.

If patient states an incident, probe for: what led up to the event, what were the involved persons thinking and feeling, and the outcome. The goal of these questions is to vividly understand the origins of the feelings and how it has impacted his or her view of therapy. Shame is commonly associated with the sense that one is intrinsically bad and inadequate; and fear may originate from a specific person, cultural values, or judgments. Was s/he afraid of a specific person, thought, or situation, or a specific group of people, and why?

Can you help me to understand what caused you to feel afraid of this situation? Were you afraid of anything related to therapy? Sometimes, people are afraid of feeling inadequate or facing a 'failure,' or their inability to manage themselves or feeling as though they're being manipulated. Some people are afraid of entering therapy because it feels uncertain and unsettling. Has this occurred to you?

7. *Physical Barriers – e.g. finances, transportation, etc*

Let's talk about other challenges that may have dissuaded you from going to therapy.

Health Insurance

Prior to entering therapy, did you have health insurance? Did your lack of health insurance affect your willingness to enter therapy? Can you help me to understand how it affected you?

Resourcefulness

Prior to entering therapy, did you know where to look for a psychologist? Can you tell me what your experience of looking for a psychologist was like? How much time did you initially spend on the process of finding a psychologist? Where did you look for a psychologist? Did the lack of available psychologists affect your willingness to enter therapy?

Lack of Available Resources

Have you ever tried to schedule an appointment with a psychologist and failed? Can you tell me about that experience? What was your impression of therapy after this experience?

Financial Means

Prior to entering therapy, did you believe that therapy was beyond your financial means? Did you think treatment was affordable? Was a portion of your income budgeted for therapy? Did your lack of income affect your willingness to enter therapy? Can you help me to understand how?

Time Commitment

Was time commitment a challenge for you to entering therapy? How much time did you believe you needed to commit to participate in therapy? Was this time that you did not think you had? Can you help me to understand why you did not have this time? What occupied most of your time? Did your lack of available time affect your willingness to enter therapy? Can you help me to understand how?

Means of Traveling

Did you believe that visiting a psychologist required you to travel beyond your means and availability? Were there any other physical or geographic challenges that made it difficult to enter therapy? Did you have a means of getting to the psychologist's office? How did this affect your willingness to enter therapy? Can you help me to understand how?

OVERCOMING THE BARRIERS TO TREATMENT

1. **Tell me about what the process of entering therapy was like.** Was there a breaking point for you?
 2. Talking to a stranger provides the comfort of a detached relationship versus talking to closer friends who get worked up and make her more anxious. Talking to people closest to you is not comforting... **which issues are you not comfortable bringing up with your closest friends?** Why? Are they people you can rely upon? **Did you desire someone to talk to about these concerns?** Who are the most important people to this person?
 3. **Is anyone close to you involved or affiliated with mental health?** Has anyone in your family received support through psychological services? What was your conversations related to mental health like with this person? **How did it change your views of therapy, if at all?**
-

Appendix B

INFORMED CONSENT

Rutgers, The State University of New Jersey INFORMED CONSENT

Overcoming the Barriers to Mental Health Treatment Services in Korean American populations

The current study is trying to understand how Korean Americans seek mental health treatment. A number of studies have shown that only a small minority of Korean Americans seek support from a mental health professional. While the research literature has identified a variety of culturally based treatment barriers to explain why Korean Americans may not choose psychotherapy, the process for those who enter psychotherapy is unclear. This study aims to understand this process by exploring the personal challenges of entering psychotherapy and the ways in which they were overcome.

This study will gather its data qualitatively in a semi-structured interview over the course of two to three 45-minute interviews as well as from several questionnaires that aim to assess your level of acculturation and adherence to traditional Asian values. Altogether, participation in this study requires approximately 90 to 120 minutes of your time.

You will be asked to reflect on your emotional, cognitive, and behavioral processes prior to entering psychotherapy. The interview includes the reasons for entering therapy, the internal and external obstacles in entering therapy, and the process of overcoming these challenges. The sensitive and personal nature of this interview may cause you to feel slight discomfort during the administration.

Your participation in this study is strictly voluntary. You have the option to withdraw from the study and choose not to participate at any time without any penalty to you. You may also choose not to respond any question with which you are not comfortable answering.

Maintaining confidentiality of subject's identities is highly important in this study. Identifying information, such as your name, address, phone number, date of birth, etc., will not be recorded with the data. All hard copies of the research data will be securely kept in a locked filing cabinet. Additionally, all audio recordings are saved in a password protected, digital media format. My research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated.

This research study will provide useful information on mental health treatment accessibility among Korean Americans, with the potential to yield additional studies on accessibility and outreach of mental health services. The findings will help to understand the important processes among Korean Americans who are considering mental health treatment services. This data may help Korean Americans enter treatment and guide mental health outreach to Korean American populations.

If you have any questions about the study procedures, you may contact Paul Park at (424) 903-6339 or ppark@eden.rutgers.edu, or Karen Riggs Skea, Psy.D. at (732) 247-7489. If you have any questions about your rights as a research subject, you may contact the Sponsored Programs Administrator at Rutgers University at:

Subject Initials: _____

Rutgers University Institutional Review Board for the Protection of Human Subjects Office of
Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: (732) 932-0150
Email: humansubjects@orsp.rutgers.edu

You will be given a copy of this consent form for your records.

Your completion of the study procedures represents your agreement to participate in the research.

Thank you,

Paul Park
Principal Investigator

Participant's Name

Date

Appendix C:

DEMOGRAPHIC DATA QUESTIONNAIRE (DDQ)

1. Age: _____
Gender: _____
2. Years of Education (to date): _____
3. Major in College: _____
4. Current Profession: _____
5. Have you been in psychotherapy before?
 - a. When did you begin? _____
 - b. For how long? _____
 - c. What type of setting? _____
 - d. How many other psychologists? _____
 - e. Times? _____
6. Country of Origin: _____
7. Age of Immigration to the U.S. (if applicable): _____
8. Father's Country of Birth: _____
9. Mother's Country of Birth: _____