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# A Cross-sectional Study on Korean American Mental Health Challenges and Help-seeking Behavior

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and Help-seeking Behavior

by

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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# ACKNOWLEDGEMENTS

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# ABBREVIATIONS

| | |
|---|---|
| AA | Asian American |
| AHUM | Anderson Healthcare Utilization Model |
| CD-RISC | Conner-Davidson Resilience Scale |
| CRT | Critical Race Theory |
| HB | Hwa-byung |
| HLR | Hierarchal Linear Regression |
| KA | Korean American |
| MH | Mental Health |
| MHS | Mental Health Services |
| NAMI | National Alliance on Mental Illness |
| NIH | National Institute of Health |
| NIMH | National Institute of Mental Health |
| PMHS | Professional Mental Health Services |
| ATMHS | Attitudes Toward Mental Health Services |
| RCOPE | Brief Religious Coping Scale |
| SF-12 | Short Form Health Survey 12 Item Scale |
| US | United States |

ABSTRACT OF THE DISSERTATION

A Cross-sectional Study on Korean American Mental Health Challenges
and Help-seeking Behavior

by

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Mental distress in the Korean American community remains chronically high yet professional service utilization is amongst the lowest of any ethnic group in the United States. With high rates of co-morbidity in this community, it is critical to utilize a multi-level approach to understand the scope of distress of distress by simultaneously analyzing the occurrences of anxiety, depression, and *hwa-byung* (a Korean cultural illness), in addition to studying factors that impact help-seeking behavior.  To contextualize the unique circumstances and factors that impact mental health challenges and resource utilization in the community, Critical Race Theory and Anderson's Healthcare Utilization Model was utilized to frame the diverse experiences and perspectives.

Separate hierarchal linear regressions for anxiety, depression, and *hwa-byung*, were run, controlling for socio-demographic variables in the first step and potential protective factors in the second step. Two logistic regressions were run to analyze formal and informal resource utilization. Results showed that the language they took the survey in, income, church role, and generational status significantly predicted distress scores. Perceived better physical health status, higher perceived resiliency, positive views of God and/or religion appeared to serve as potential protective factors for distress. Level of education, employment status, and religious affiliation significantly predicted formal

service utilization. Factors that predicted informal resource utilization were gender, attitudes toward professional mental health services, acculturation, and views of God and religion.

It is suggested that future studies be conducted to further explore which types of interventions would be most effective in not only decreasing mental distress but also in identifying interventions or resources people are most likely to use based on intersections of roles and experiences.

**CHAPTER ONE**

**INTRODUCTION**

Recent estimates show that over 1.7 million Korean-Americans (KAs) reside in the United States (U.S.) making it the fifth largest Asian subgroup and the seventh largest immigrant group in the U.S. (U.S. Census Bureau, 2010). Since the year 2000, the KA population has increased by 38.2%, and the increasing population trend is expected to continue throughout this coming decade (Terrazas & Batog, 2010). In contrast to the long history of immigration of Chinese and Japanese Americans, the majority of KAs immigrated after the *Immigration Reform Act* of 1965 (which abolished the national origins based quota system that had previously restricted immigration from Asia) (Hurh, 1998). Approximately 79% of Korean adults in America are foreign born (Pew Research Center, 2012). Despite their short immigration history in the U.S., 53% of KA adults 25 and older obtained at least a bachelor's degree (in comparison to national share of 28%) and earned more than the national medium income, and made inroads into fields, such as medicine and engineering that has been historically been dominated by white men (2012). However, the pressure to maintain this image of success has led to the KA community downplaying issues, such as high rates of mental health challenges among KA adults (Bernstein, Park, Shin, Cho, & Park, 2011).

KAs are twice as likely to report depressive symptoms than that of the general U.S. population (Bernstein et al., 2011) but are less likely to utilize mental health services than various minority groups in the U.S. (Chin, Waters, Cook, & Huang, 2007). Distress levels may be attributed to acculturation, according to Kim, Seo, & Cain (2010) who found that preference for Korean culture was associated with depressive symptoms have

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lower income, and have limited English proficiency (which were also associated with higher distress rates) (Bernstein et al., 2011). Gender also appeared to play a role with KA women are significantly more distressed than KA men as found in Chun, Khang, Kim, & Cho's study (2008).

The mental health struggles that KA women face is further exacerbated by the significant mental health challenges among KA men. While KA women are more likely to be diagnosed with mental health issues, KA men were more likely to be diagnosed with major depressive disorder than any other group of Asian American males (Kim, Park, Storr, Tran, & Joun, 2015; Kuo, 1984). Moreover, in a culture where mental health help seeking is stigmatized (Shin, 2002), KA men are reported to engage in self-treatment for depression and other mental health issues resulting in high rates of alcohol abuse and domestic violence against women (Duranceaux et al., 2008; Helzer et al., 1990; NKI Focus Group Report, 2012). Women in the KA community remain silent, reflecting the fear of breaking racial solidarity and pressure to maintain an image of strong family bonds, high educational attainment, wealth, and privilege. However, this hides the underlying issues of very real issues of both physical and mental distress for both genders (Lee, 2009).

With approximately 71% of the KA population identifying as Christian (PEW Research Center, 2012), Korean ethnic churches provide critical support and often are the networking system for Korean immigrants (Chong & Gul, 1991; Kim & Kim, 2001). Being involved in these churches not only provides fellowship with other Korean immigrants and ways to maintain Korean culture, it also a way for Korean immigrants to find social services. Church involvement can also improve social status and positions for

adults (Min, 1992; Chai, 2001; Chong & Gul, 1991; Kim & Kim, 2001). A recent qualitative study that explored mental health perspectives in the KA community revealed that church leaders, particularly pastors, are also often the first line of help when members are faced with social, financial, and/or mental health issues (Baek, Ortiz, Alemi, Mann, & Montgomery, n.d.). However, while church leaders may have more access and awareness about mental health issues, they themselves arguably have more limitations on accessing services when faced with their own personal struggles, believing that if they are open with their mental health struggles, it could harm their trustworthiness in the community and they may be perceived as incompetent (Baek et al., n.d.). Therefore, it is critical to specifically assess factors that influence mental distress for church leaders.

## Theoretical and Conceptual Framework

### *Critical Race Theory*

When analyzing the intersecting factors that influence how mental distress is expressed and experienced, one must also seek to understand the unique experiences and oppression for KAs. This calls for different strategies to deconstruct the current power relations. The struggles that KAs face at both the macro and micro level can be viewed through the theoretical lens of Critical Race Theory (CRT). Specifically, CRT is used to establish the history of marginalization of KAs through policy and impact of being labeled as the model minority, how KA mental health conceptualizations and the performativity of gender create barriers to seeking help, and how one's social location and identity contribute to mental distress.

According to CRT, racism is embedded and normalized in everyday society and that intersections of societal categories are factored into how policies are staged, often benefiting those in power at the expense of marginalized groups (Delgado & Stefancic, 2012). When analyzing the impact and intersection of class, race, and gender, the focus typically divides those that are privileged and those that are oppressed. However, access to privilege is rarely so clear-cut in which one group is able to hoard all the resources while the other groups are left destitute. There is also the complexity of the consequences of privilege, in particular for marginalized or minority groups. Take for example, those that are identified as model minorities. On the surface, the term model minority may not appear to have any negative connotations. It projects an image of high income, educational levels, family stability, and low rates of crime – which reflects the majority of Korean families. Yet the purpose of developing the term model minority has been to divide Asians from other minority groups. Furthermore, it has been used to justify the lack of attention and resources to address issues such as the increasing concern about mental health needs in the Asian American (AA) community (Hall & Yee, 2012; Wu, 2008; Junn & Masouka, 2008; Miranda, McGuire, Williams, & Wang, 2008). In addition, the essentialist notion that all Asians are the same disregards the issues or the diverse experiences within the AA communities, justifying the lack of policies that recognizes the diversity in the AA community and scarcity of culturally sensitive resources to meet the unique needs of each ethnic group, such as the KA community (Hurh, 1998; Chen, Sullivan, Lu, & Tazuko, 2003; Shin, 2010).

Korean Americans conceptualize mental health holistically, in which spiritual, physical and psychological components are interwoven (Leong & Lau, 2001). Therefore,

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mental health conditions are perceived to be an imbalance between the body, mind, and environment (Cheung, Leung, & Cheung, 2011). However, mental illness is seen as an indication of personal weakness and lack of self-discipline (Shin, 2002) and believed to be hereditary and shameful to not only themselves but also to their families (Jang, Chiriboga, & Okazaki, 2007).

When analyzing the various factors that influence mental distress, one must also be aware of the intersections (and inequalities) of said components. Intersectionality views how fundamental factors of inequality (race, gender, class, and sexuality) mutually define and reinforce one another and cannot be conceptually and empirically separated from each other (Cole, 2009). Cole (2009) states that "intersectionality makes plain that gender, race, class, and sexuality simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions" (pp. 179). People occupy multiple roles/categories simultaneously and these social categories depend on each other for meaning, which can also vary depending on the social context (Cole, 2009), which is why it is critical to attend to the diversity (focusing, in particular, neglected groups) within social categories to be able to accurately analyze how the categories depend on one another for meaning. Analyzing the inequality of certain intersecting roles helps conceptualize how the hierarchies of privilege and power structure social and material life.

### Anderson Healthcare Utilization Model

The Anderson Healthcare Utilization Model (AHUM) is based on the assumption that there are three major factors that influence resource utilization: 1) predisposing

factors (i.e. race, age, health beliefs, culture), 2) enabling factors (i.e. family support, access to care) and 3) need (the perceived and actual need for resources) (Anderson, 1968). Utilizing this model allows us to contextualize multiple aspects that impact professional help-seeking behavior and type of personal coping methods. This provides information for both formal and informal sources of support and ways to allocate resources to effectively address the rates of distress in the KA community.

By applying CRT and the AHUM through quantitative methods in the specific context and intersections of race, culture, gender, generational status, and acculturation, this study will seek to understand how KA Christians in the U.S. experience, perceive, and cope with mental health challenges.

**Nature and Statement of the Problem**

Mental health challenges are perceived to be a dysfunction of cognition and lack of self-control in Korean culture, thus openly talking about mental health challenges (or challenges in general) and seeking help is highly stigmatized (Shin, 2002). In a culture where the needs of the community and maintaining a harmonious environment take priority, interpersonal relationships are elevated before individual needs or struggles (The National Alliance on Mental Health, 2007), and there appears to be no culturally acceptable outlet for feelings such as distress and anger (Kim, Kim, & Kelly, 2006). This may lead to the development of mental health issues, such as *hwa-byung* (HB), a culturally constructed mental disorder manifesting from chronically suppressed feelings of anger that is primarily. Studies conducted by Leong & Lau (2001) and Karasz (2005) revealed that the perception of mental illnesses as a lack of self-control or discipline is

still prevalent. The silence about these challenges in the community is also perpetuated by the belief said challenges must be dealt with within the family (Okazaki, 2000; Lin & Parikh, 1999) especially with older, first generation KAs (Park, Cho, Lee, Sohn, Seong, Suk, & Cho, 2015).

In addition, the more individualistic and egalitarian western culture is a direct contrast to the hierarchal Korean culture, where teamwork and networking is a critical component of life (Kim, Kim, & Kelly, 2006). First generation KAs often struggle with the language barrier in addition to difficulties in adjusting to a shift in lifestyle and thought. While acculturation may not necessarily be significantly related to depression (Kunsook, Park, Shin, Cho, & Park, 2011), lower English language proficiency has been linked to higher depressive symptoms and other mental illnesses (Kunsook et al., 2011). For KAs that live in large Korean communities or if another family member speaks English, learning English may be perceived as unnecessary, further isolating the individuals and limiting resources, particularly if they need or want services that are not available in Korean.

While cultural barriers play an important role in how the KA community deals with mental health challenges, institutional infrastructures have also failed to provide adequate support and resources. Historically, U.S. federal mental health policy has largely overlooked KA and continued to systematically undermine the need for culturally appropriate services to better meet the various and diverse needs of this community. While policies such as the Community Mental Health Centers (CMHC) Act of 1963 and the Patient Protection and Affordable Care (PPAC) Act of 2010 has removed some of the barriers to accessing services (Hall & Yee, 2012), there are still critical changes that must

be made. Research and development of cultural appropriate services for KAs has to become a higher priority. There needs to be increased support and awareness at both the community and national level to recognize and meet mental health needs of the diverse nationalities and cultures within the KA community.

## Significance of the Issue

The belief that mental health problems resonate from a lack of self-control and therefore mental health conditions should be dealt with individually or within the family was identified as a deterrent to seeking help for mental health conditions (Shin, 2002). The difficulty of finding services that were culturally sensitive to the needs of the KA community, which is reflected in U.S. mental health policy, largely overlooked AAs and continued to systematically undermine the need for culturally appropriate services to better meet the KA community's various and diverse needs (Hall & Yee, 2012).

Korean churches are often identified as central locations for resources (Chong & Gul, 1991; Kim & Kim, 2001), with church leaders are usually serving as the first line of support when community members seek help for social, financial, and mental health challenges (Chong & Gul, 1991). However, while church leaders may have more access and awareness about mental health issues, they themselves arguably have more limitations on accessing services when faced with their own personal struggles, believing that if they are open with their mental health struggles, it could harm their trustworthiness in the community and they may be perceived as incompetent. In addition, the lack of culturally sensitive resources and the stigma surrounding mental illness (Bernstein et al., 2011) increases the risk of burnout. There are few acceptable outlets for mental distress,

few people that they can talk to about their struggles, and difficulty finding people who understand their situation. In addition, there is limited literature that assesses the extent of mental distress in addition to barriers and facilitators to help-seeking among church leaders.

Therefore, the significance of understanding factors that influence mental distress within the KA community rest on several factors: 1) rapidly growing KA population, 2) the persistently high rate of mental distress, 3) low rate of mental health service utilization likely due the cultural stigma surrounding mental illness and the availability of culturally-sensitive mental health interventions, 4) limited literature on the mental distress for church leaders, and 5) limited information about informal sources of support to cope with mental distress.

**Study Aims**

It is evident that a culturally focused study, guided by CRT methodology and the AHUM is needed to further understand 1) the scope and factors that influence mental distress among KAs and 2) factors that influence formal and informal resource utilization. Therefore, I propose that this study answer the following research questions.

1.1.What is the occurrence of *hwa-byung* (HB), depression, and anxiety symptoms?

1.2. Are there differences between gender, age, generational status, and church roles in the occurrence of distress symptoms?

1.3 Do higher levels of acculturation, positive attitudes toward professional mental health services, better physical health status, positive religious coping,

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higher levels of resilience, and higher levels of social support act as protective buffers for mental distress?

2.1. Does gender, age, generational status, and church role have a direct and/or indirect (through enabling and need factors) influence on formal and informal resource utilization?

2.2. Does level of acculturation, attitudes toward professional mental health services, religious coping, level of resiliency, and level of social support exert a direct influence on formal and in formal resource utilization?

2.3. Does *hwa-byung*, depression, and anxiety have a direct influence on formal and informal resource utilization?

# CHAPTER TWO

# LITERATURE REVIEW AND THEORETICAL/CONCEPTUAL FRAMEWORK

## Theoretical Underpinnings

Critical Race Theory (CRT) will be used to explore the different levels of oppression that Korean Americans (KAs) face. Specifically, the CRT tenets of anti-essentialism and intersectionality will be applied to establish the structural barriers impeding KAs from receiving culturally appropriate care and how the intersection of culture, gender, and role expectations contribute to the mental distress.

## Summary of Critical Race Theory

Critical Race Theory asserts that racism is embedded in the very foundation and institutions of society (Delgado & Stefancic, 2012). Intersections of societal categories are factored into how policies are set up and who benefits and who is marginalized as well as who is making the decisions. Built on the foundation of critical legal studies and radical feminism, CRT examines the social constructionism of law and American society and culture through the intersection of race, law, and, most importantly, power. Eschewing the soft, careful liberalism's method of downplaying the influence of race in the justice system, CRT argues against the liberalism's embracing of color blindness, stating that justice is not blind and in order to address the inequalities in the justice system, the relationship between law and racial power needs to be transformed to achieve racial emancipation and anti-subordination (Delgado & Stefancic, 2012).

Four theoretical themes explain the social constructionism and perpetuation of racism. The first is interest convergence, material determinism, and radical realism.

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Delgado & Stefancic compare two groups – "idealists" who hold that "racism and discrimination are matters of thinking, mental categorization, attitude, and discourse" and the "realists" who hold that "though attitudes and words are important, racism is much more than a collection of unfavorable impressions of members of other groups…[rather it] is a means by which society allocates privilege and status" (2012, pp. 21). Realists, making the large majority of CRT theorists in the early years, believe that racism is deliberately constructed to justify the unequal opportunities and allocation of resources and the exploitation of minorities. They argue that any civil rights progress made coincide with the self-interest of the dominant group and that very little has to do with altruism and the interest of minorities. Directly confronting the impact of race in power relations, CRT proposes that white privilege and supremacy are maintained over, with the law being manipulated to maintain the status of the privilege and to oppress minorities.

Revisionist history criticizes civil rights scholarship and anti-discrimination law, citing the Brown v. Broad of Education as an example. Derrick Bell, one of CRT's founders, argued that civil rights advances for blacks coincided with the self-interest of white elitist. According to Bell, sympathy and evolving standards of social decency had less to do with the Supreme Court voting in favor of Black education. In 1954, there were various factors that would serve detrimental to the self-interest of whites if changes were not made. African American service workers returning from the Korean War were less likely to willingly subservient themselves to menial labor in addition to social vilification after having lived in an environment where cooperation and survival took precedence over racism – which could have led to the possibility of mass domestic unrest. In addition, with the rest of the world observing the United States during the Cold War, if

they got wind of the gross mistreatment and injustice towards minorities in the United States, it could upset the U.S. global stance on protecting freedom and democracy (Delgado & Stefancic, 2012). Mary Dudziak performed extensive archival research in the US Department of State and US Department of Justice, as well as the correspondence by US ambassadors abroad. She found that passing of the laws in the U.S. was not because people of color were discriminated against, rather it was to improve the image of the US to Third World countries that the US needed as allies during the Cold War (Delgado & Stefancic, 2012).

Dissatisfied with the liberal stance of color blindness and neutral principles in the constitutional law, CRT scholars argue that this only holds true if the legal system is free of bias. However, CRT asserts that racism in embedded in the very foundation and institutions of society and that assuming the color blindness of the legal system only continues to subjugate and oppress minorities and that only "aggressive, color-consciousness efforts to change the way things are will do much to ameliorate misery" (Delgado & Stefancic, 2012, pp. 27). Color blindness, while admirable in theory, assumes that everyone is on an equal playing field and that crimes or perceptions of crimes and the allocation of punishments have nothing to do with one's class or race, which is rarely, if ever, the case.

According to CRT, structural determinism, a mode of thought or widely shared practice, determines significant social outcomes. Usually this occurs without conscious knowledge and because of this, our system cannot redress certain kinds of wrongs (Delgado & Stefancic, 2012). Structural determinism calls for law reform, stating that the traditional tools are outdated and lead to solutions that have never worked. Rather,

frameworks and concepts such as intersectionality, interest convergence, antiessentionalism, hegemony, hate speech, language rights, black-white binary, and jury nullification need to enter the official vocabulary of the law to address and deconstruct racism in the legal system (2012). Going back to the criticism of the "idealist", the authors also warn against falling into empathic fallacy. This is the belief that one can change a narrative by offering an alternative narrative in hopes that the listener's empathy will quickly and reliably take over. Empathy is not enough to change racism as most people are not exposed to many people different from themselves and people mostly seek out information about their own culture and group (2012). Racism goes beyond changing one's way of thinking and attitude. One must also understand the embeddedness of racism and how it is acted out everyday in seemingly innocuous actions, which are compounded into devastating effects, which can be seen in microaggressions. Microaggression refers to the sudden, stunning, or dispiriting transactions that mar the days of people of color (Nakaoka & Ortiz, 2017). These include small acts of racism consciously or unconsciously perpetrated and act like water dripping on a rock wearing away at it slowly. Microaggressions are based on the assumptions about racial matters that are absorbed from cultural heritage (Delgado & Stefancic, 2012). The perpetuation of racism creates victims of both the perpetuator and the oppressed in addition to occurring at all levels of society.

**Critical Race Theory Tenet: Anti-Essentialism**

Despite increasing concern about mental health needs in the Asian American (AA) community, this group has been largely neglected when it comes to allocation of

mental health resources. Harmful myths and perceptions, such as AAs are the model

minority and thus do not experience mental health issues (Hall & Yee, 2012; Junn &

Masouka, 2008; Wu, 2008) or mental health disparities (Hall & Yee, 2012; Miranda,

McGuire, Williams, & Wang, 2008) have been used to justify the neglect of the

communities' mental health needs. In addition, one of the great challenges to better

understand the mental health issues in the AA community is that the label Asians covers

a diverse group of nationalities and cultures (Hurh, 1998), calling for a need to explore

mental health needs within the different cultural groups (Chen, Sullivan, Lu, & Tazuko,

2003; Shin, 2010). With KAs one of the fastest growing Asian populations in the U.S.

and the rising rates of mental distress, it is becoming increasingly critical to explore why

the mental health needs of this community are still being largely unmet.


### *Mental Health Care Policy*

While cultural barriers play an important role in how the KA community deals

with mental health challenges, institutional infrastructures have also failed to provide

adequate support and resources. From the late 1800s, the government systematically

undermined AAs' human rights, which included excluding them from citizenship to the

internment of Japanese Americans (Gee, Ro, Shariff-Marco, & Chae, 2009). This

institutionalized discrimination was justified by false research that linked certain

communicable disease to specific racial and ethnic groups and in order to protect and

maintain the health of the public, that these groups had to be controlled (Gee & Ro,

2009). While measures to reduce institutionalized discrimination and barriers to care have

been made, AAs are still least likely to utilize professional mental health services (Baquet

et al., 2004; Chin et al., 2007; Ku and Waidmann, 2003; Leong & Lau, 2001; SAMHSA, 2008).

Triggered by the Civil Rights movement, the Community Mental Health Centers (CMHC) Act of 1963 focused on increasing access of resources to individuals who had the greatest need by establishing community mental health centers, allowing for more people to be able to utilize and access mental health services, especially for minorities (Hall & Yee, 2012). Mental health care services shifted from state hospitals to outpatient care in local communities, with community mental health centers required to provide inpatient and outpatient services, emergency services, and partial hospitalization as well as consultation and education services in addition to being encouraged to provide other services such as pre- and aftercare services, diagnostic services, and rehabilitative services and also provided funding for research and evaluation. Kiesler (1992) and Stockdill (2005) found that while the changes instigated by the CMHC act increased service utilization in the AA community (as cited in Hall & Yee, 2012, pp. 3), it was still far lower than White Americans. Sue's (1977) study also found that AA were more likely to prematurely terminate services (as cited in Hall & Yee, 2012, pp. 3). The stigma and shame associated with mental illness (Shea & Yeh, 2008; Jang et al., 2009; Huang et al., 2007) and the lack of awareness of the importance of mental well-being (Bernstein, 2007) along with the systematic discrimination they faced from the government (Gee et al., 2009), may have deterred many from the community from accessing and utilizing the CMHC services. A 2001 study by Ryu, Young, & Park analyzed the impact of health insurance on health service utilization found that having health insurance was the strongest predictor on whether they utilized services, regardless of the need. They found

that KAs that have no insurance are significantly less likely to utilize services than those that had insurance, suggesting that having insurance also was a critical factor in regard to utilizing services.

While the CMHC Act appeared to be a positive step in increasing access to mental health services by bringing care back into the community based clinics, providing culturally sensitive mental health for AAs was still being neglected (Gee & Ro, 2009) which was especially concerning with the rapid growth of AAs in the mid 1960s (Deaux, 2006). This issue was further exacerbated when the Omnibus Budget Reconciliation (OBR) Act of 1981 repealed the CMCH Act (Hall & Yee, 2012). Stockhill (2005) argued that individualist arguments based on the premise that everybody had equal rights and access to resources and services (therefore, special attention or programs for particular cultural groups was deemed unfair) shifted the focus from increasing access to those in greatest need to those that had the ability to pay (as cited in Hall & Yee, 2012, pp. 2). This led to the closing of community mental health centers and the rise in private mental health care services – excluding individuals who could not afford private insurance coverage (Kiesler, 2000). Thus, even increasing coverage for both mental and physical health (through the Mental Health Parity Act of 1996 and the Wellstone-Domenici Parity Act of 2008) did not address the issue of accesssiblity to services for those with limited or no health care insurance. In addition, increasing the quality of care was focused on the needs of White Americans (Hall & Yee, 2012).

The widespread use of ESTs and EBPs to evaluate care led to a focus on finding the cause of the mental illness from the fault of the individual to that of biology in 1989. The purpose of these studies was to de-stigmatize mental illness by using biology to

explain the causes and effects and to conceptualize them as diseases (Miller, 2010). However, while the biological focus on mental illness appeared beneficial of Asian communities since there were fewer stigmas associated with physical disorders than psychological illnesses (2012), this framework did not take into account cultural or sociocultural influences (i.e. immigration stress, discrimination). In addition, the "focus on the brain as the basis of psychopathology is based on the assumption that studies of White Americans and their concurrent findings can be generalized to other ethnic groups" (Hall & Yee, 2012, pp. 4), further marginalizing Asian Americans and other culturally diverse groups.

While the Patient Protection and Affordable Care Act of 2010 provided health insurance to many who were previously uninsured and allowed a greater number of people the ability to pay for existing health care services including mental health care services, there was still little emphasis on providing culturally relevant services, in particular for psychological services (Hall & Yee, 2012). In summary, U.S. federal mental health policy has historically largely overlooked KA and continued to systematically undermine the need for culturally appropriate services to better meet this various and diverse needs of this community. Policies such as the CMHC Act of 1963 and the Patient Protection and Affordable Care Act of 2010 have removed some of the barriers to accessing services but there are still critical changes that must be made. Research and development of cultural appropriate services for KAs must become a higher priority. There needs to be increased support and awareness at both the community and national level to recognize and meet mental health needs of the diverse nationalities and cultures within the KA community.

## Critical Race Theory Tenet: Intersectionality

When studying immigrant communities, there are various aspects and factors that shape the community. However, one must also take into consideration that these influences are also fluid and can change depending on the context and the various roles the individual plays. Intersectionality takes the construction of said reality and addresses power inequalities. While all individuals play a part in the social construction of reality, there are groups that assert a greater influence on the rest of society, depending on where one falls in the matrix of intersecting factors. Intersectionality views how fundamental factors of inequality (race, gender, class, and sexuality) mutually define and reinforce one another and cannot be conceptually and empirically separated from each other (Cole, 2009). Cole states that "intersectionality makes plain that gender, race, class, and sexuality simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions" (2009, pp. 179). People occupy multiple roles/categories simultaneously and these social categories depend on each other for meaning, which can also vary depending on the social context (2009). Which is why it is critical to attend to the diversity (focusing in particular neglected groups) within social categories to be able to accurately analyze how the categories depend on one another for meaning. When analyzing the role that inequality plays helps conceptualize how the hierarchies of privilege and power structure social and material life. Intersectionality also seeks commonalities across categories often viewed as very different, leading to fragmented society due to ignoring similarities (2009), which in turn perpetuates the cycle of inequality and unfair division.

Despite studies showing that marginalized individuals demonstrate less dogmatic beliefs and are more open to new ideas and act as "cultural brokers" (successfully negotiate expectations rooted in contrasting worldviews), there is still a significant relationship between marginality and mental distress among AAs. While considered a part of a marginalized group, Asians are also seen as part of the "model minority"[1]. While there are positive associations with this label such as high income, educational levels, family stability, and low rates of crimes, there is also pressure to maintain this image as any type of deviance from the ideal image is heavily criticized and discouraged. Immigrants tend to construct positive, idealized ethnic identities about gender that challenge hegemonic representations of immigrants (Cole, 2009; Mahalingam & Leu, 2005) (i.e. women are chaste, virtuous and more family oriented than American women and men are more responsible, dependable, and hard working than American men). However, these ideals to resist racial denigration lead women to be more tolerant and internalize hyper-masculine and patriarchal values to provide space for immigrant men to redeem their masculinity (Cole, 2009; Mahalingam & Leu, 2005). This can also significantly hinder help seeking for issues such as domestic violence or mental illnesses.

### *Women's Mental Health Challenges*

One critical aspect of intersectionality is the importance of ensuring that all voices have the opportunity to be heard (Cole, 2009), in particular those that face multiple oppression. To understand the shaping of the persona and performativity of KA women, one must also analyze the socio-historic impact on the construction of gender and race.

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[1] A model minority is a minority group whose members are most often perceived to

Korean American women have been marginalized throughout history (Choi, 2004; Resos, 2013) and face oppression culturally and institutionally. According to the patriarchal Confucianism system, women were to occupy lower positions then men at every level and that it was natural and proper that women were subservient to men. Neo-Confucianism reinforced the authority of the men as well as the patrilineal customs. Women were only acknowledged and accorded power and honor after marriage as a mother and as a mother-in-law. The husband, the husband's family, the children then the mother was the order of rank in the family. An admirable woman was unselfishly loyal with self-sacrificing willingness to do anything to assist her husband and his family (Cho, 1998).

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Measures or efforts to improve the experiences and lives of women in Korea faced cultural resistance, especially when it called for major changes or the doing away with the patriarchal Confucianism system ideals about women's roles. During the New Women's Movement in Korea in the 1920's, leaders of this movement challenged the moral system of Confucian patriarchy, identifying this sociopolitical system as the main

force of cultural oppression for Korean women. These activists advocated for love between women and men regardless of marriage, marriages that were not arranged by parents, and the obliteration of the dominant feminine chastity ideology, which was heavily influenced by Confucian thought, openly acknowledging the influence of Western feminism and Christianity (Kwon, 1998). However, the most prominent leaders of this movement became social pariahs. Scholars' explanations as to the movement's limitations or failures varies from the gap between the movement's Western practices and traditions of Korean society being too large at that time to the activists lacking the nationalist consciousness and in turn, the social obligation of colonized women. The impact Japanese colonization on women created an additional sense of societal obligation (Kwon, 1998). Korean women struggled with the social and cultural aftermath of failing to live up to the Confucius driven ideology of a virtuous, chaste women when they were forced to fulfill the roles of meeting the sexual needs of the Japanese army as "comfort women" during Japanese occupation (Kwon, 1998).

It is critical that one also reflects on the potential resistance from both men and women to preserve the Confucius patriarchal system and the impact of Japanese colonialism (that women should be punished for "allowing" themselves to be raped) may have (Kwon, 1998). KA women are expected to present this "ideal" image of the chaste, virtuous wife, facing a more complex form of oppression and are even less likely to be able to seek help and/or support from the community (Choi, 2004).

### *Barriers to Care for Korean American Religious Leaders*

KAs often approach their religious leaders when seeking help for mental health challenges. There have been studies that explored the roles that religious leaders play in the KA community in addition to their mental health literacy (Yuri et al., 2016; Lee, Hanner, Cho, Han, & Kim, 2008). There are also studies that provide suggestions on how professional mental health service providers can deliver culturally sensitive[2] care to the KA community (Huang, 2007; Lee et al., 2008). However, there is very limited literature and focus on the unique mental health struggles that they themselves and their family members face due to their position in the community. The intersection of their role as a trusted community leader, Korean culture and the limited access to culturally appropriate care, places church leaders at greater risk of mental distress with more barriers to services and resources. There is very limited literature that seeks to understand the level of mental distress among church leaders or what factors impede or assist in seeking professional mental help. This is further exacerbated by lack of culturally appropriate care (Hall & Yee, 2012). Therefore, a theoretical framework that focuses on the intersection of socio-demographic factors and barriers to care is essential to gain a deeper understanding of mental distress among church leaders.

### **Mental Distress in the Korean American Community**

### *Hwa-byung*

The multiple stressors that KAs experience can lead to a culture-bound syndrome called *hwa-byung* (HB), which literally means "anger disease" or "fire disease". It is a

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[2] Culturally sensitive care is defined as using a holistic approach that embraces culture and takes into consideration of ethnicity, gender, age, and SES into care.

culture related syndrome related in anger in Korea (DSM-IV; American Psychiatric Association, 1994) and is primarily identified as Korean women's illness (Min, Suh, & Song, 2009; Min et al., 2009; Lee et al., 2012). It is a chronic anger syndrome, in which anger is thought to have been chronically suppressed and accumulated, becoming dense and is characterized by unique symptoms including partially suppressed anger and somatic and behavioral manifestation of partially expressed anger (Min, Suh, & Song, 2009). While the sufferer eventually expresses their rage and anger, it does not improve (or even worsens) the situation that caused the anger, creating a cycle of frustration at failing to change or situation in addition to failing to release the anger, eventually leading to somatic symptoms. Most patients with HB have multiple diagnoses – the most common comorbidities being depressive disorders, atypical somatization disorder, and generalized anxiety disorder. HB is a stand-alone diagnosis and the patient does not necessarily have to suffer from multiple or any other mental illnesses (Min et al., 2009). However, the symptoms of HB heavily overlap with the symptoms of depression, anger suppressement, and generalized anxiety disorder (GAD). Shared symptoms with major depressive disorder (MDD) are difficulty concentrating, remembering details, making decisions; fatigue, decreased energy; feelings of guilt, worthlessness, helplessness; pessimism, insomnia, early morning wakefulness, excessive sleeping, irritability, restlessness; loss of interest in hobbies or activities (including sex); over-eating, appetite loss; persistent aches, pains, headaches, cramps, digestive problems that do not ease with treatment; persistent sadness, anxiety, "empty" feelings (Lee et al., 2012). The main differences between HB, MDD, and GAD appeared to be the prolonged length of time it takes for HB to develop (10 – 40 years). A 2012 study examined the relationship between

acculturation, the presence of HB, and Western-influenced symptom presentation among the first and second-generation Korean adults living in the United States. The study indicated that first generation Koreans were less likely to be acculturated and were more likely to report somatic HB like symptoms (Min & Shu, 2010).

### *Depression*

Those suffering from HB are highly likely to also struggle with depression (Min & Shu, 2010). Factors that may contribute to the high levels of depression among the Korean immigrant community may be language barriers and stress with work and family. In addition, acculturative stressors, such as struggling to balance two cultures that are at odds with each other, may also be a major contributing factor. A 2008 study conducted on KAs showed that a lack of social support was strongly correlated with high levels of acculturative stress and that depressive symptomology is correlated with a lack of social support and with high levels of acculturative stress (Choi, 1997). In addition, first-generation immigrants were more likely to report Western-influenced depressive symptoms than second generation participants in a cross sectional study on acculturation, HB, and Western-influenced symptom presentation conducted on first generation Korean immigrants in the United States (Min & Shu, 2010). While there is a term for depression in Korean, it does not carry the same cultural meaning and impact and is not as socially acceptable to talk about depression. At the core of HB are the cultural concepts, *han* and *jeong*. This is a reflection of a "deep bitterness" or "deep sorrow" due to unresolved injustice and the hope to overcome avenge the injustice. It brings together Koreans as a community – while it may not be acceptable to express individual sorrow, there is this

understanding of shared suffering, easing the burden of the grief carried. Being able to differentiate between HB and depression can inform how culture can play a role in defining mental illnesses as well as the impact on mental health.

### *Anxiety*

While there a few studies conducted on anxiety on the Korean population, it may be due to the overlap of symptoms between HB and depression. All the major symptoms for GAD are found in the symptomology of HB. In addition, anxiety may not be viewed as a mental illness. Rather, it may be perceived as a part of normal, everyday life; as part of the collective suffering that is part of Korean culture, such as *han*. While individuals may not feel as if they have HB or depression, it is more acceptable to express how anxious or worried they feel. Therefore, further studying how anxiety, in addition to HB and depression, impacts KAs may provide valuable information on core issues that affect this group.

### Anderson Healthcare Utilization Model

While there are persistently high rates of mental distress in this community (Bernstein, Park, Shin, Cho, & Park, 2011; Gee, Ro, Shariff-Marco, & Chae, 2009; Hurh, 1998; Kim, Park, Storr, Tran, & Joun, 2015), KAs continue to have significantly lower rates of professional mental health utilization than other ethnic groups (Chin, Waters, Cook, & Huang, 2007; Gee, Ro, Shariff-Marco, & Chae, 2009; Ryu, Young, & Park, 2001). However, there is the essentialist notion that "all Asians are the same" disregards the issues or the diverse experiences within the AA communities, justifying the lack of

policies that recognizes the diversity in the AA community and scarcity of culturally sensitive resources to meet the unique needs of each ethnic group, such as the KA community (Hurh, 1998; Chen, Sullivan, Lu, & Tazuko, 2003; Shin, 2010). As one of the fastest growing Asian ethnic subgroups in the United States (U.S. Census Bureau, 2010), it is becoming increasingly critical to use a multi-level framework to study factors that impact help-seeking behavior among KAs. The Anderson Healthcare Utilization Model is based on the assumption that there are three major factors that influence resource utilization: 1) predisposing factors (i.e. race, age, health beliefs, culture), 2) enabling factors (i.e. family support, access to care) and 3) need (the perceived and actual need for resources) (Anderson, 1968). Utilizing this model allows us to contextualize multiple aspects that impact professional help-seeking behavior and type of personal coping methods. This provides information for both formal and informal sources of support and ways to allocate resources to effectively address the rates of distress in the KA community.

### *Predisposing Factors*

Walker (2006) argues that the terms and models used in the mental health profession are all socially constructed. Therefore, one must also understand how mental health is contextualized in order to identify causes of mental health conditions, the factors that deter people from using mental health services, and being able to develop culturally relevant interventions. A critical component in developing culturally sensitive services is the understanding the conceptualization of mental health in the KA community. Asian worldviews on the dynamics between the mind and the body tend to be more holistic, in

which psychological and physical problems are inseparable and psychological disorders are biological in nature (Leong & Lau, 2001). Koreans also perceive mental health conditions to be a lack of balance between their body, mind, and environment (Cheung, Leung, & Cheung, 2011) and are more likely to seek help for psychological distress from a physician than a mental health professional. There is also the belief that mental health conditions are hereditary and shameful to not only themselves but also to their families (Jang, Chiriboga, & Okazaki, 2007). Mental health challenges are perceived to be a dysfunction of cognition and lack of self-control in Korean culture, thus openly talking about mental health challenges (or challenges in general) and seeking help is highly stigmatized (Shin, 2002). One of the basic tenets of Korean culture is to maintain harmony and to suppress social discord in which suffering is perceived as unavoidable aspect of life. The repression of feelings and frustration is perceived to be a sign of maturity and strength. One should not burden others with their pain. "*Han*" or a timeless sorrow that is an inherent and part of Korean cultural identity exemplifies this tenet. This is not an individual state of being. Rather, it connects the sufferer to Korean society and culture. Through this perspective, it appears that sadness and repression of strong feelings is not so much a social illness. Rather it is an integral aspect of Korean identity. The second core cultural concept is "*jeong*" which can be described as a strong feeling of kinship or interpersonal trust and emotional bonding. Maintaining harmonious interpersonal relationships often takes precedence over all other considerations. The further one is away from an individual, the more important it becomes to at least maintain a peaceful environment. This is not to say that sharing pain or frustrations does not occur, especially among close friends. However, there is still the expectation, even during

difficult times, to be solicitous of the other person's time and comfort (The National Alliance on Mental Health, 2007). The last core concept that will be introduced is "*noon-chi*", which is the capacity to quickly evaluate another person or social situation. Closely interrelated with "*jeong*", being able to accurately assess a situation and act accordingly is critical in maintaining the harmonious environment (The National Alliance on Mental Health, 2007). The issue appears to be that there is no culturally acceptable outlet for such feelings of distress and anger (The National Alliance on Mental Health, 2007; Kim, Kim, & Kelly, 2006).

Gender also appeared to play a role with KA women are significantly more distressed than KA men as found in Chun, Khang, Kim, & Cho's study (2008). Furthermore, while KA women are more likely to be distressed than men (Chun et al., 2008), KA men were more likely to be diagnosed with major depressive disorder than any other group of East Asian males (Kim, Park, Storr, Tran, & Joun, 2015). Moreover, in a culture where help seeking for mental health problems is stigmatized (Shin, 2002), KA men are reported to engage in self-treatment for depression and other mental health issues as demonstrated in studies showing high rates of alcohol abuse and domestic violence (Rhee, 1997) in addition to acculturative stress (Choi, 2008). Korean woman are expected to be virtuous, self-sacrificing, submissive, obedient, and put the well being of her family above all other matters. Those who do not fit the persona are either culturally forced into obscurity (i.e. shunned from the community) or deliberately disassociate themselves from the community. This invisibility of those that do not contribute to ideal persona of Korean femininity helps maintain this image (Lee, 2009).

Studies conducted by Leong & Lau (2001) and Karasz (2005) revealed that the perception of mental health challenges as a lack of self-control or discipline is still prevalent, keeping struggles a secret within the family (Okazaki, 2000; Lin & Parikh, 1999) especially with older, first generation KAs (Park, Cho, Lee, Sohn, Seong, Suk, & Cho, 2015).

In addition, high rates of KAs without health insurance pose an additional barrier for mental health services utilization in the KA community (Ryu, Young, & Park, 2001). Compared to other Asian subgroups in the US, KAs have higher rate of self-employment (Huang, 2013). Policies that undermine the need for culturally relevant services and resources further exacerbate mental health struggles in the KA community (Gee, Ro, Shariff-Marco, & Chae, 2009).

### *Enabling Factors*

Korean Americans tend to live in or near large cities within prominently Korean communities, to help maintain their ethnic identities and cultural ties with Korean churches having long served as the main source of community support and solidarity (Kim, Kim, & Kelly, 2006). The more individualistic and egalitarian western culture is a direct contrast to the hierarchal Korean culture, where teamwork and networking is a critical component of life (Kim, Kim, & Kelly, 2006). First generation KAs often struggle with not only the language barrier but also face difficulties in adjusting to a shift in lifestyle and thought. While acculturation may not necessarily be significantly related to depression (Kunsook, Park, Shin, Cho, & Park, 2011), lower English language proficiency has been linked to higher depressive symptoms and other mental illnesses

(Kunsook et al., 2011). Kim, Seo, & Cain (2010) found that preference for Korean culture was positively associated with the occurrence of depressive symptoms. Bernstein et al. (2011) found that low income and limited English proficiency were also associated with high distress rates. Learning English as a KA goes beyond that of simply memorizing new vocabulary, the rules of grammar, and learning the proper pronunciation. It also calls for a change in attitude. Berger and Luckmann emphasized the importance of language, calling it the medium of thought (1966). Korean has different hierarchies of speech in which one can express respect or lack of respect for one's position in society. The type of honorifics used speaks of the variability of power and solidarity of Korean society (Hijirida & Sohn, 1986; Strauss & Eun, 2001). However, English does not have these structures in hierarchy in the language. The sentence structure, the tone of voice, and the speech patterns also differ. The Korean sentence structure is considered to be "passive" while everyday English is usually spoke in an "active" voice. This switch from "passive" voice to "active" voice also influences the customary way of speaking of issues and/or conflicts to speaking in a more direct manner (Park, 2009). Having to adjust to this new way of speaking may add additional stressors to acculturating to American culture and explain why English proficiency has such a significant impact on mental health status for first generation KAs in the United States.

With approximately 71% of the KA population identifying as Christian (PEW Research Center, 2012), Korean ethnic churches provide critical support and often are the networking system for KAs (Chong & Gul, 1991; Kim & Kim, 2001). Being involved in these churches not only provides fellowship with other KAs and ways to maintain Korean culture, it also a way for KAs to find social services. Church involvement can also

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improve social status and positions for adults (Min, 1992; Chai, 2001; Chong & Gul, 1991; Kim & Kim, 2001).

*Need*

Approximately 30-54% Korean-Americans suffer from depression (Bernstein, Park, Shin, Cho, & Park, 2011; Kang, Basham & Kim, 2013; Kim, 2012; Kim & Im, 2015; Kim, Sangalang & Kihl, 2012; Lee & Hadeed, 2009; Roh, Lee, Lee, Shibusawa & Yoo, 2014; Sin et al., 2011) yet are less likely to seek professional mental health services to help cope with mental distress than other minority groups (Chin, Waters, Cook, & Huang, 20074, 7). In addition, there are high levels of co-morbidities with anxiety and a cultural mental illness called *hwa-byung* (HB) with Koh's (2018) study showing similar rates of severe depression (18.2%) and anxiety symptoms (16.9%). There are several overlaps in symptomology between depression, anxiety, and HB (Min & Shu, 2010). HB is a mental disorder caused by chronically unresolved and suppressed feelings of unresolved injustice, anger and sadness which eventually manifest into somatic symptoms, such as stomach issues, fatigue, and chest pains (Min, Song, & Suh, 2009). A study by Baek et al. (n.d.) also showed highly significant positive relationships between HB, depression, and anxiety scores.

**Significance of the Issue**

The significance of understanding factors that influence resource utilization within the KA community rest on several factors: 1) the fast growing population, 2) the persistently high rate of mental distress, 3) low rate of mental health service utilization

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likely due the cultural stigma surrounding mental illness and the availability of culturally-sensitive mental health interventions, and 4) limited information about informal sources of support to cope with mental distress. Therefore, it is critical to examine factors that influence the use of formal and informal resource utilization for mental distress among KAs from multiple levels.

## Conclusion

The belief that mental health problems resonate from a lack of self-control and therefore mental health conditions should be dealt with individually or within the family (Shin, 2002) is significant barrier that was identified as a deterrent to seeking help for mental health conditions. The difficulty of finding services that were culturally sensitive to the needs of the KA community, which is reflected in U.S. mental health policy, has largely overlooked AAs and continued to systematically undermine the need for culturally appropriate services to better meet this various and diverse needs (Hall & Yee, 2012). Policies that provide funding for community support, such as the CMHC Act, may help reduce barriers in accessing services.

With intense scrutiny and higher levels of expectations with minimal support from the community, it is becoming increasingly urgent to listen to the narratives and understand the unique mental health challenges of Korean Americans as well as understanding strengths in addition to seeking viable solutions to meet the needs of this community. Using the critical race methodology and the Anderson Healthcare Utilization Model, guided by literature and qualitative preliminary research study, the study will

explore the scope and differences in the manifestation of HB, depression, and anxiety, and barriers/facilitators that impact resource utilization.

It is suggested that interventions use cultural capital that exists in the community by utilizing Korean churches to build an acceptance for both formal and informal mental health services and resources. With the collaboration of KA churches, an increase in awareness and dissemination of information could help break down the stigma of mental illnesses and distrust of mental health service providers.

# CHAPTER THREE

# PRELIMINARY RESEARCH

# COMMUNITY LEADERS' PERSPECTIVES ON KOREAN AMERICAN

# INTERSECTIONAL MENTAL HEALTH CHALLENGES AND SOLUTIONS

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# Abstract

This study explored Korean-American (KA) community leaders (CL) and service providers (SP) insight on how the KA community conceptualizes mental health challenges, as well as perceived barriers and facilitators to seeking mental health services (MHS). Nineteen semi-structured interviews using the qualitative description method, framed by social construction, were conducted with CLs and SPs. Age, acculturation, gender, limited MH awareness, and lack of culturally sensitive services were identified as factors influencing help-seeking behavior. CLs and SPs were also identified as vulnerable subgroups. Collaboration with Korean churches and culturally sensitive school-based interventions were suggested as possible solutions. Findings support existing literature illustrating the importance of culturally applicable, accessible MHS. Further study on CLs and SPs in the KA community is recommended.

*Key Words***:** community leaders, Korean-American, mental health, southern California

**Background**

Despite increasing concerns about mental health conditions in the Asian-American (AA) community, dedication of private and public funding to provide accessible and culturally sensitive mental health care continues to be limited for this minority group (Hall & Yee, 2012). This lack of financial support is attributed in part to the notion that AAs, as a "model minority", do not experience mental health challenges (Wu, 2008), as well as the exploration and presentation of mental health concerns for AAs as an aggregate group (Miranda, McGuire, Williams, & Wang, 2008). Disaggregation of AAs into subgroups is among the primary challenges to a better understanding of mental health issues in differing AA communities, as the overarching label "Asians" covers considerably diverse groups of nationalities and cultures. When mental health needs are not explored within different AA groups (Wu, 2008), many issues go overlooked and vulnerable groups remain underserved, such is the case of Korean-Americans (KAs). When included under the umbrella term of "Asians", the unique circumstances of the KA community are often missed, making it difficult to understand the distinct factors that impact the mental health of this population.

Recent estimates report over 1.7 million KAs in the United States (U.S.). KAs are the fifth largest Asian ethnic sub-group and the seventh largest immigrant group in the U.S. (U.S. Census Bureau, 2010). Between 2000-2010, the KA population increased by 38%, a trend that is expected to continue, according to Terrazas and Batog (2010). In contrast to the long history of Chinese and Japanese immigration to the U.S., the majority of KAs immigrated after the *Immigration Reform Act* in 1965, explaining why over three-quarters of Korean adults in America are foreign born (Pew Research Center, 2012). KAs

tend to live in or near large cities within prominently Korean communities, to help

maintain their ethnic identities and cultural ties, with Korean churches having long served

as the main source of community support and solidarity for the community (Kim, Kim, &

Kelly, 2006).

## Mental Health of Korean-Americans

KAs were twice as likely to report depressive symptoms than the general U.S.

population (Bernstein, Park, Shin, Cho, & Park, 2011) but were less likely to utilize

mental health services than other minority groups in the U.S. (Chin, Waters, Cook, &

Huang, 2007). Mental health problems for KAs may be attributed to acculturation,

according to Kim, Seo, & Cain (2010) who found that one's preference for Korean

culture was associated with depressive symptoms. Bernstein et al. (2011) found that low

income and limited English proficiency were associated with high distress rates and

Chun, Khang, Kim, & Cho's study (2008) found that gender also plays a role, with KA

women being significantly more distressed than KA men.

Furthermore, while KA women are more likely to be distressed than men (Chun et

al., 2008), KA men were more likely to be diagnosed with major depressive disorder than

any other group of East Asian males (Kim, Park, Storr, Tran, & Joun, 2015). In a culture

where help seeking for mental health problems is stigmatized (Shin, 2002), KA men are

reported to engage in self-treatment for depression and other mental health issues, as

demonstrated in studies showing high rates of alcohol abuse and domestic violence

(Rhee, 1997) in addition to acculturative stress (Choi, 2008).

Of note, compared to other Asian subgroups in the U.S., KAs have higher rate of

self-employment (Huang, 2013) leaving high numbers of KAs without health insurance, which then poses as an additional barrier for mental health services utilization in the KA community (Ryu, Young, & Park, 2001). Finally, policies that undermine the need for culturally relevant services and resources further exacerbate mental health struggles in the KA community (Gee, Ro, Shariff-Marco, & Chae, 2009).

**Korean-American Concepts of Mental Health**

Asian worldviews on the dynamics between the mind and the body tend to be more holistic, in which psychological and physical problems are inseparable and psychological disorders are biological in nature (Leong & Lau, 2001). Koreans also perceive mental health conditions to be a lack of balance between their body, mind, and environment (Cheung, Leung, & Cheung, 2011) and are thus more likely to seek help for psychological distress from a physician than a mental health professional. There is also the belief that mental health conditions are hereditary and shameful not only to themselves but also to their families (Jang, Chiriboga, & OKAzaki, 2007). Adverse mental health experiences may also be perceived as an indication of personal weakness, which contribute to the cultural sigma about openly discussing mental health challenges and seeking help (Shin, 2002).

In the KA community, churches therefore serve as a pillar of both spiritual/religious support and social support. Church leaders, particularly pastors, can heavily influence how psychological distress is expressed and also impact help seeking behavior in this community (Hwang et al., 2008; Lee et al., 2008). The study by Kim-Goh (1993) showed that pastors who conceptualized mental illness psychologically were

far more likely to refer those that sought help to professional mental health services. In contrast, pastors who conceptualized mental illness as a religious issue were more likely to view mental health conditions as religious delusions and were far less likely to make a referral to mental health services. Together, the results from Lee et al. (2008) and Kim-Goh's (1993) studies support the need to increase KA pastors' awareness of and training in a culturally cognizant way about mental health conditions to better equip them when approached by community members seeking help. Therefore, understanding community leaders, including pastors' beliefs about mental health and attitudes towards help-seeking is critical for future efforts in addressing mental health needs and services in KA communities.

## Theoretical Framework

Building on prior research with KAs, the purpose of this paper is to explore how key-informants believe the greater Los Angeles (L.A.) Korean community conceptualizes mental health challenges, and barriers and facilitators to seeking professional mental health services. Berger & Luckmann's (1966) theory on *social construction* served as a theoretical lens in exploring these topics. Perception of mental health as a social construction in the KA community is highly dependent on the ways social phenomena (mental health) is created, institutionalized, and integrated in everybody knows life of KAs. Because social constructs are facets of reality and objects of knowledge, they must be constantly maintained and re-affirmed in order to persist (Berger & Luckmann, 1966). Walker (2006) argues that the terms and models used in the mental health profession are all socially constructed. Therefore, one must also understand how mental health is

contextualized in order to identify causes of mental health conditions, the factors that deter people from using mental health services, and being able to develop culturally relevant interventions.

The significance of understanding mental health challenges within the KA community rest on several factors: 1) the rapid growth in their numbers in the U.S., 2) the prevalence of mental health challenges and disorders; and, 3) their underutilization of mental health services likely due to a lack of psychoeducation, health insurance, and the availability of culturally-sensitive mental health interventions.

## Methods

### *Sampling & Recruitment*

Inclusion criteria for this study were being a KA community stakeholder with intricate knowledge of the community and/or a service providers who provides health or mental health services to at least one KA client, in addition to speaking English fluently and being over the age of 18. Using a combination of convenience and snowball sampling strategies, participants were recruited across the greater L.A. area. Maximum variation sampling strategies were used to recruit participants in order to reach saturation in representation of the various of mental health perspectives by recruiting both genders of varying ages, educational levels, birthplace (foreign and U.S.-born), and length of residence in the U.S. Participants were recruited via phone or email that detailed the purpose of the study, the inclusion criteria, and meeting arrangements if they agreed to participate.

## *Interview Procedures*

Data were collected through semi-structured face-to-face interviews by a qualitatively trained interviewer between January and June 2017. Interviewing continued until theoretical saturation was achieved (Patton, 2002). The semi-structured interview guide (for consistency across interviews) covered the following topics: 1) KA perceptions of mental (ill) health, 2) factors that influence help seeking behaviors, and 3) possible solutions needed to address the mental health challenges in this community (see Table 1 for complete interview guide). Participants were referred by community leaders in the KA community and later on by other participants (snowball sampling). Before interviewing began, the researcher reviewed the informed consent document (ICD), which explained the purpose of the study and participant's rights. The study was approved by the Loma Linda University Institutional Review Board. ,Upon signing the consent form, participants were asked to complete a brief paper-pencil form assessing their socio-demographic characteristics, include their type and length of involvement in the KA community as a leader. Please see below for the complete interview guide.

**Table 1.** Interview question guide

1) What do you think are the strengths in the Korean community?

2) What challenges do you think the community faces?

3) How do you describe/refer to mental health challenges?

4) What are mental health challenges in the Korean community?

   a.  How serious do you think the issue is?

   b. How do you think people cope with mental health challenges?

   c. What about gender differences?

   d. Differences in types of health challenges?

   e. What are the physical effects?

   f. What are the generational differences?

6) What role does Korean culture play in how the community deals with mental health challenges?

   a.  What are the barriers? Support?

7) Where do people go for help when dealing with mental health challenges?

8) Who do you think face the most barriers when trying to access resources or help? Why?

9) What suggestions do you have to remove the barriers that stop people from seeking help?

10) What would you do to help other KAs who experience challenges in the community?

### *Qualitative Data Analysis*

Qualitative description (QD) was used to provide a low-inference description of data that described the informant's experiences in their own language or as similar as possible (Sandelowski, 2000). The structured interview guide used in QD allows the researcher to gather the "purest" or unspun/non-theorized form of description in a particular area of interest. While only a straight descriptive summary can be rendered using QD, summaries may lead to working hypotheses or key categories for future theory-based research (Neergaard, 2009).

Six analytic strategies proposed by Miles & Huberman (1994) were used to guide our qualitative content analysis: 1) coding of data from interviews, 2) recording insights and reflections on data, 3) sorting through the data to identify similar phrases, patterns, themes, sequences, and important features, 4) looking for commonalities and differences among data and extracting them for further consideration and analysis, 5) deciding on generalizations that hold true for data, and 6) examining these generalizations in the light of existing knowledge.

### *Establishing Trustworthiness and Rigor*

In order to ensure trustworthiness and rigor**,** the authors used the following strategies, recommended by Patton (2002): 1) ensuring participant's confidentiality, 2) data triangulation, by recruiting a diverse array of stakeholders possessing different roles within the community, as well as service providers, 3) member checking by discussing new data with participants that had been interviewed earlier, and 4) research reflexivity by debriefing with coauthors to identify own biases during the data collection process, and 5) incorporating verbatim statements that were linked to descriptions of data.

### Results

### *Sample Characteristics*

A total (N) of 19 Key Informants (KI) (16 community stakeholders and 3 service providers) participated in this study. The average age was 36.97 (*SD*=10.98) years and over 70% had a graduate degree. The majority of the KIs (66.67 %) were born outside of the U.S. and spent at least 5 years actively working in the KA community. Service

providers (social worker, physician, psychiatrist) had an average of 30 KA clients per

year. See Table 2 for the demographic table.

**Table 2.** Socio-demographic characteristics of sample (N = 19)

|  | Key Informants M(SD) or n | Service Provider M(SD) or n | Total M(SD) or n |
|---|---|---|---|
| Age (26-65) | 37.15 (12.20) | 36.33 (1.53) | 36.97 (10.98) |
| Gender |  |  |  |
| Female | 11 | 0 | 11 |
| Male | 5 | 3 | 8 |
| Education |  |  |  |
| Bachelors | 6 | 0 | 6 |
| Graduate | 10 | 3 | 13 |
| Generational Status |  |  |  |
| 1st | 5 | 1 | 6 |
| 1.5 | 6 | 0 | 6 |
| 2nd | 5 | 2 | 7 |
| Years Active in Community (5-35) | 9.57 (11.34) | 7.00 (3.61) | 8.28 (11.39) |
| Annual Number of KA clients (25-250) |  | 108.33 (123.32) |  |

Three major themes were identified: 1) factors influencing perception and help

seeking behavior, 2) barriers that prevent access to mental health resources and services,

and 3) participant identified solutions to address mental health challenges in the

community.

***Theme 1: Factors Influencing Mental Health Perceptions and Help-Seeking Behaviors***

When KI's were asked how they thought the KA community perceived mental

health (which they used interchangeably with mental illness), they responded that older,

less acculturated KAs perceived mental health as "craziness" or lack of sanity and were

most resistant to utilizing professional mental health services. They were also identified

as being hyper vigilant about physical ailments, suggesting that it is more acceptable to

seek help for physical ailments than to share that one is suffering from psychological

distress.

The physician (SP, male, mid 30s) mentioned that his patients often disclosed

their mental health challenges to him rather than seeking mental health services. One

respondent felt that mental health was perceived as a loss of control or discipline stating:

> I think they would view somebody as having mental issues as somebody who has
> really gone off the cliff. But something like depression…I think the Korean
> attitude would be that it's not something that would be viewed as a mental health
> issue but rather something to fight through. It's just a phase (KI, female, mid 20s).

The second generation appeared to have more awareness and knowledge about

mental health, strongly associated it with emotional well-being and felt that mental and

physical health was equally important. They perceived having to balance two conflicting

cultures with pressure from their parents to do well financially and educationally as the

main threat to their mental health.

> Language barriers and culture play a huge role for migrants or immigrants. For
> the second generation, they are forced to accept/balance two cultures and their
> parents pressure them to succeed and to do well financially and educationally (KI,
> female, mid 40s).

All participants agreed that there is still a major stigma about openly talking about mental

health challenges, even for those that were open to the idea of seeking professional

mental health services. A KI (female, late 40s) shared that she had not been aware of her

brother's chronic mental illness until her parent's passed away and her brother was left in

her care. She felt that her brother had been kept out of the public eye and isolated to

shield the family from judgment and criticism from the community. She believed that

while the social support and networking in the community was a strength, it also led to

higher levels of scrutiny and pressure to present an image of success, driving people to stay silent about their struggles with mental illness.

Another KI (male, mid 30s) disclosed that when he personally was faced with mental health challenges, he did not want to reach out to his social supports and isolated himself until he felt that he overcame the challenge. Reflecting back on his experience and now having more information about mental well-being, he still felt that he would reach out to family and friends rather than seeking services, believing that how he dealt with his depression was common in the KA community.

KIs also shared that most KAs needing mental health support sought help from their pastors. However, many felt that most pastors were not adequately educated and trained in recognizing symptoms of poor mental health nor were they aware of information or resources (referrals). A female KI (late 60s) stated *"mental health in the [Korean] Christian community, they feel like it's a curse…a sin…"* In addition, KIs felt that many Korean pastors believed that mental illness was a lack of control or a result of a sinful nature and often identified prayer as a more appropriate solution rather than referring their members to mental health services. While agreeing that prayer was important, KIs felt that pastors needed to be trained and informed about mental illnesses as well as linked to mental health resources. However, even with the training and awareness, pastors were reluctant referring church members.

> If I recommend it…well, I'm very careful about recommending because if I were to recommend, sometimes parents misunderstand what I'm saying and they get angry at you…because it's like you're identifying their kid as a problem… If people think about going to see a mental health service provider, they automatically think, "I have a problem". And they don't like to acknowledge [that] (KI, male, late 40s).

When probed to see if KIs noticed gender differences in regard to mental health challenges in the KA community, the main difference appeared to lie in help seeking behavior. It appeared to be more culturally acceptable for women to speak about mental health struggles and seek help. A service provider who worked primarily with older KA clients stated:

> I'll recruit a service provider who offers mental health service in Korean to do a presentation [at the senior residential facility]. It's mostly women though. Men, I have to build that trust with them first before I can even talk to them about things like depression – and that can take a long time. But I think it might be different for women. Women tend to feel more comfortable talking [about] stress or anxiety. But for men, [they] don't want to admit [they] have problems (SP, male, late 30s).

### Theme 2: Barriers to accessing or Receiving Mental Health Services

When asked, which groups they felt had the most difficulty accessing services, KIs spoke about vulnerable groups that are often not perceived as marginalized, such as those who are service providers themselves. One KI shared that her husband, a KA doctor, felt that when faced with mental health challenges, he could not openly seek help, fearing that it would negatively impact his image and sense of competency.

> I feel like people who think that they have a lot to lose, you know, like doctors. Like, if someone hears that Korean doctor sees a psychologist, psychiatrist, or these counselors… they're the ones who probably need the most help but are not going to…because of their stressful jobs and home life…because it would impact their reputations…(KI, female, late 30s).

KIs also believed that individuals such as pastors and their wives had difficult seeking help fearing that it would negatively impact their image if the community were aware of their mental health challenges.

> Wives of pastors…again, very isolated, there's a lot of domestic violence, uh…in the community as a whole, but also in families where the male figure is a pastor and so, again, I would say pastor's wives don't have an alternative or place to go

because it would ruin their spouse's career and ministry which would then ruin their lives too…Those individuals [are] very much isolated and condemned and marginalized, maybe even demonized (KI, female, late 40s).

When probed about other barriers to services, participants noted that while there had been more culturally sensitive resources offered in the past, services offered in Korean currently were difficult to find or expensive. They felt that the mental health needs of the Korean community were being overlooked by both public and private funding sources because of perceptions such as being part of the "model minority".

> The model minority myth kills our community. I think a lot of the challenges that exist…they are either overlooked, ignored, or dismissed. And I even think also racism and hate crimes are also overlooked and dismissed because we don't have our political voice in place. Um… and I would say because of the model minority myth, the investments, the research is also lacking and that prevents resources from coming in to the community to build the infrastructure for organizing, for leadership, for training, for advocacy (KI, female, late 40s).

KIs expressed their frustration that when resources were available, there were times that people they referred were not able to utilize them because of language barriers:

> Yeah….and then I saw one for Asian Americans but might as well go to an English one because it was…because…it was Pan Asian, the only language they could speak was English (KI, female, late 40s).

### *Theme 3: Participant's Recommendations for Addressing Mental Health Challenges*

When KIs were asked to share how they saw one could address the mental health challenges that they noticed in the community they identified underutilization of mental health services as one of the main issues. To increase access to services and resources, participants stated that an ideal starting place to build support and acceptance for mental health services in Korean churches.

> The two most powerful mobilization vehicles are the ethnic media as well as Korean churches (KI, female, late 40s).

Another KI supported that, saying:

> You have to get help from someone who's well-respected in the community, who is like a leader. And for them to have a counselor and to start talking about like it's normal, it's oK.…I feel like that's the best way for Koreans to start opening their minds. That it can work. For pastors to say that "we get help". If the pastor can get help, maybe I can too (KI, female, mid 30s).

Therefore, with the influence of churches and church leaders, it was suggested that there be an increased effort for mental health organizations and providers to collaborate with Korean churches, in particular those that provide the most protective buffers, to increase awareness and to disseminate information to help break down the stigma of mental illnesses and distrust of mental health service providers. There was also emphasis on increasing awareness and transparency about mental health challenges and its prevalence:

> I think that they should be less scared in seeing weakness in their children. And instead of telling them to suck it up and to quickly get them get through that so-called phase of weakness, I think they should help that child identify what emotion that they're feeling and where it's coming from and they should talk through it (KI, female, mid 20s).

> Given the critical importance of family and the strong emphasis in success in children, another KIs suggested focusing interventions on families—working with children and parents as a gateway to opening up the discussion about mental health.

> [Focus on] how to help their children manage…I think that would hit people. Because they're always interested about their kids, their education and their stuff, more so than be their own personal things…so they get good grades, be more sociable by helping them [improve] their mental health. Then I think parents will go to listen, to help their kids, but at the same time, you can put a little input about how parents needs to be [mentally] healthy so that the children can be healthy. (KI, male, late 50s).

## Discussion

The purpose of this qualitative study was to explore perceptions of mental health amongst community leaders in the KA community within the greater L.A. area. We

interviewed KA community leaders and service providers, and queried them on how they believed the KA community conceptualized mental health, the factors that impact help-seeking behaviors, and possible solutions to address mental health challenges within KA communities. Participants indicated that mental health concepts and help seeking behaviors within KA communities vary by age, acculturation, and gender. For example, older KAs view good mental health as maintaining sanity and self-control, (and the opposite as craziness and lack of control) whereas younger KAs associated good mental health with emotional wellbeing.

Though in further explaining this finding, the more positive views attributed to mental health by younger KAs is likely due to their acculturation to American culture, and western education, exposing them to a better and less stigmatized understanding about mental health and mental disorders, therefore framing mental health in a more positive light (Cheong, Leong, & Cheong, 2011). Moreover, with regard to gender differences in help seeking behaviors, KIs suggested that women may be more inclined to openly speak about their mental health struggles and to seek professional help. Our findings align with previously published studies exploring mental health concepts in diverse AA subgroups (Jang, Chiriboga, & Okazaki, 2009) and the cultural acceptance for women to express hardship and ask for help in regard to mental health challenges (Wendt & Shafer, 2015).

While acculturation and gender may likely mediate the use of professional mental health services as shown here, stigma, according to our participants, poses a significant barrier to seeking help. This finding provides some explanation to the high rates of (untreated) depression and low mental health service utilization rates found among KAs

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in previously published studies (Shin, 2010). This is further exemplified in the KI narratives with relation to the notion that mental health problems resonate from a lack of self-control and therefore mental health conditions should be dealt with individually or within the family (Shin, 2002).

Another barrier that was identified as a deterrent to seeking help for mental health conditions was the difficulty of finding services that were culturally sensitive to the needs of the KA community, which is reflected in U.S. mental health policy, that has largely overlooked AAs and continued to systematically undermine the need for culturally appropriate services to better meet various sub-population's diverse needs (Hall & Yee, 2012).

Many also raised the need for awareness of subgroups that are typically not perceived as marginalized or vunerable. This includes pastors and service providers who are often simply expected (without training) to serve in a mental health service role. Indeed, KAs often approach their religious leaders when seeking help for mental health challenges. There have been studies that explored the roles that religious leaders play in the KA community in addition to their role as mitigators of mental health literacy (Lee, Hanner, Cho, Han, & Kim, 2008; Yuri et al., 2016). Since the mental health field is not one selected by many KAs professionals, some have suggested that KA health professionals should function as mental health service providers as well, as they can deliver culturally sensitive[3] care to the KA community (Huang, 2007; Lee et al., 2008). Overall however, there is very limited literature and focus on the mental health struggles

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[3] Culturally sensitive is defined as using a holistic approach that embraces culture and takes into consideration ethnicity, gender, age, and socio-economic status.

that they themselves face with these additional set of expectations, especially as they themselves often struggle with their own misconceptions and prejudices about mental health.

Therefore, the question arises how we can reframe the concept of mental health for KAs? Some have called for education about mental health conditions having a biological basis and can be treated through medication and/or therapy (Lee et al., 2008; Shin, 2002), which continues to put the onus on health professionals. Others suggest using more ecological approaches that emphasize the use of community-based support systems, which may be more feasible (Yuri et al., 2016; Lee et al., 2008).

Participants identified pastors or churches as the most common source of support that the community sought when seeking help for mental health challenges. However, there as also consensus that pastors often did not have the knowledge of mental health resources and were not adequately equipped or trained to deal with mental disorders. The lack of trained pastors was also seen in Kim-Goh's study (1993). In addition, while Kim-Goh (1993) and Lee et al. (2008) also support the suggestion for mental health training for pastors, it did not appear to address the potential backlash of recommending mental health services to those that perceived mental illness as insanity or a personal weakness.

With respect to this, our observations suggest that being involved with a church not only provides fellowship with other Koreans and a means of maintaining ethnic ties and Korean culture, it is also an avenue for Koreans to find accessible social services. Kim et al. (2006) has suggested that having community centers located at or near churches that utilize a holistic framework that provide an array of culturally-appropriate physical, mental, and spiritual services. Using churches as a gateway to opening the

dialogue about mental health without expecting pastors and their wives to handle this alone, could help increase awareness and ease the stigma against seeking mental health services.

While there was limited literature regarding the implementation of preventative measures in schools with large KA populations, our results support providing culturally sensitive services to families who often struggle with their children moving away from the traditional culture. If these types of interventions were to be offered at schools or at churches it would offer and opening to promote conversations to increase awareness and safe place to talk about mental health challenges.

### Strengths, Limitations, and Future Study Directions

The use of a theoretical sample was a limitation in the study. However, given the sensitivity of the topic, recruiting a systematic diverse sample of experts seemed a logical first step to gaining further insight on how to approach this issue in the KA community. While small, we found data saturation across the emerging themes which for the most part were supported by the limited existing literature, therefore lending further credence to the validity of our findings. In addition to confirming prior findings we were also able to identify issue that point to the need for further research, especially regarding unexplored vulnerable sub-populations. Pastors and their wives, health providers, and mental health providers may feel deterred from being open about their own mental health struggles, believing that it could negatively impact their trustworthiness and competence in the community. The high level of stress and burnout in addition to the stigma of mental illness can make it even more difficult to utilize services and resources due to fear of

jeopardizing their reputation and standing in both their professional and cultural community. It is suggested that further studies on these groups be conducted to better understand the struggles and to develop safe access to services.

**Conclusion**

The findings from this study support previous literature that developing and providing culturally appropriate and relevant mental health resources and services for the KA community is a critical need (Hurh, 1998; Wu, Kviz, & Miller, 2009; Shin, 2010). It is also suggested that further studies exploring mental health experiences of pastors, pastor's wives, and service providers also be conducted and to consider building on the importance of family and parent/child cultural tensions to gain access to a population most often predisposed to not seek help.

Collaboration with KA churches appeared to be a key component in developing solutions to addressing barriers to services and resources in this community (Lee et al., 2008; Kim et al., 2006). The study also supported the implementation of programs and interventions in schools, potentially promoting conversations to increase awareness in addition to increasing access for both children and parents.

Overall, there needs to be increased support and awareness at both the community and national level to recognize and meet mental health needs of the diverse nationalities and cultures within the Asian community.

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**CHAPTER FOUR**

**METHODOLOGY**

**Rationale and Research Question**

Churches are often cited as the most common source of community support in regard to help with mental health challenges (Kim-Goh, 1993; Lee et al. 2008) with church leaders having significant influence in how mental health challenges are perceived and what type of help is sought in regard those challenges (Lee et al., 2008). Being involved with a church not only provides fellowship with other Koreans and a means of maintaining ethnic ties and Korean culture, it is also an avenue for Koreans to find accessible social services. Kim et al. (2006) has suggested having community centers located at or near churches that center on a holistic framework that provide an array of culturally-appropriate physical, mental, and spiritual services. Using churches as a gateway to opening the dialogue about mental health could help increase awareness and ease the stigma against seeking mental health services. However, results from the Baek, Ortiz, Alemi, Mann, & Montgomery study (n.d.) raise critical points for further research, especially regarding unexplored vulnerable populations such as church leaders. Church leaders may feel deterred from being open about their mental health struggles, believing that it could negatively impact their trustworthiness and competence in the community. The high level of stress and burnout in addition to the stigma of mental illness can make it even more difficult to utilize services and resources due to fear of jeopardizing their reputation and standing in both their professional and cultural community.

High levels of expectations, surveillance, and limited support from within and outside of the community appears to increase vulnerability to mental health challenges,

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such as depression or suicidal thoughts. There is a need for a culturally guided study to further understand the extent of the mental health challenges among Korean Americans and understanding barriers and facilitators that influence help-seeking behavior. Therefore, the research questions for this study were:

1.1. What is the occurrence of *hwa-byung* (HB), depression, and anxiety symptoms?

1.2. Are there differences between gender, age, generational status, and church roles in the occurrence of distress symptoms?

1.3 Do higher levels of acculturation, positive attitudes toward professional mental health services, better physical health status, positive religious coping, higher levels of resilience, and higher levels of social support act as protective buffers for mental distress?

2.1. Does gender, age, generational status, and church role have a direct and/or indirect (through enabling and need factors) influence on formal and informal resource utilization?

2.2. Does level of acculturation, attitudes toward professional mental health services, religious coping, level of resiliency, and level of social support exert a direct influence on formal and in formal resource utilization?

2.3. Does Hwa-byung, depression, and anxiety have a direct influence on formal and informal resource utilization?

Specifically, we hypothesize that:

**Hypothesis 1**: Older women born in Korea and church leaders will report higher

occurrences of HB, depression, and anxiety symptoms than other members of the church.

**Hypothesis 2**: Those with higher levels of acculturation, more positive attitudes toward professional mental health services, better physical health, positive religious coping, higher resilience, and more social support will have lower occurrences of mental distress symptoms.

**Hypothesis 3**: Older, first-generation men and church leaders will be significantly less likely to seek professional mental health services.

**Hypothesis 4**: Older men born in Korea and church leaders will be significantly more likely to not use any type of informal resource or used individual based informal resources.

**Hypothesis 5**: Individuals that report higher levels of acculturation, more positive attitudes toward professional mental health services, more positive religious coping, higher levels of resiliency, and higher levels of level of social support will be significantly more likely to utilize both formal and informal resources.

**Hypothesis 6**: Individuals reporting higher occurrences of HB, depression, and anxiety will be significantly more likely to utilize both formal and informal resources.

## Participants and Procedures

Participants of varying genders, ages, educational levels, and generational status were recruited. The inclusion criteria for this phase of the study entailed (a) an adult 18 years of age or older, (b) of Korean ancestry, and c) attend a Korean church in the greater

Los Angeles area (GLA). The survey (guided by the feasibility study, literature review, theoretical, and conceptual framework) used standardized measurement tools to gather information. The data for this study was collected through a questionnaire that included questions that asked about socio-demographic variables, mental health service utilization, self-reported mental distress, social support, religious coping, attitudes, what they did to personally cope with mental distress, level of acculturation, and resiliency. Participants were recruited at Korean churches located in the great Los Angeles area. The student investigator contacted churches via phone, email, and/or in person, in the greater Los Angeles area to request permission from the pastor to present to the congregation. After receiving permission, the student investigator presented an overview of the study, what the questions in the survey entailed, the incentive, and options to complete the survey. Surveys in both English and Korean were distributed at Korean churches in the greater Los Angeles Area. Participants had the option of completing and submitting the survey at the church, fill out the survey at another location or time (i.e. took the survey home and returned it the following week), for which the student investigator returned to the church the following week to collect the survey. Participants also had the option of completing the survey online via Qualtrics in either English or Korean. There was potential for emotional stress due to questions relating to participants' experiences with distress. However, the types of questions asked were made clear to the individual before asking for participation. In addition, the student investigator went over the Informed Consent Document (ICD) with each participant and provided a copy of the ICD as well as a mental health resource sheet before the survey was distributed. To minimize the political or social risk of being stigmatized for taking part in a mental health survey no identifying

information was collected. Potential participants were also offered the option of taking the survey online at a location of their choice (i.e. at home). Participants provided consent by completing and submitting the survey. A $5 donation to the church of the participant's choice was made for each survey submitted.

The student investigator is a Korean American Seventh-day Adventist and utilized convenience and snowball sampling techniques to recruit and get referrals to other churches as possible recruitment sites. Due to the importance of networking in Korean culture, the student investigator was able to achieve the greatest recruitment success at churches she had personal connections. However, in order to recruit participants that represented a wide variation of mental health experiences and perspectives, the student investigator recruited at churches of various denominations in Glendale, Granada Hills, Loma Linda, Los Angeles, Ontario, Riverside, and Yorba Linda. The data was collected from November 2017 to February 2018. The study was approved by the Loma Linda University IRB.

## Measures

### *Dependent Variables*

#### Anxiety and Depression

The Hopkins Symptoms Checklist (HSCL) 10 is a 10-item self-report symptom inventory that measures symptoms of anxiety and depression derived from a stepwise regression analysis of the HSLC 25 item scale (Derogatis, Lipman, Rikels, Uhlenhuth, & Covi, 1974). The first 4 items measure anxiety symptoms (scores ranging from 4 – 16) and the next 6 items measure depression symptoms (scores ranging from 6 – 24).

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Responses for each question are based on a 4 point Likert Scale (1 – not at all to 4 – extremely) with higher mean scores indicating more emotional distress. The international cut-off score of >1.75 for each subscale, which represents the boundary between what is "normal" and falls within the "clinical range" for symptomatic depression and symptomatic anxiety was used. This scale has been used to measure depressive and anxiety symptoms among KAs and is available in Korean and English (Cheung, Leung, & Cheung, 2011). The internal reliability for anxiety (Cronbach's alpha = 0.81) and depression (Cronbach's alpha = 0.75) were within the acceptable range.

**Hwa-byung**

The *hwa-byung* (HB) Scale consists of 15 most common symptoms associated with HB: anger, *uk-wool/boon* (a Korean culture-related sentiment related to social unfairness), heat sensation, pushing-up in the chest, difficulty breathing, stomach pain, insomnia, headache/pain, dry mouth, anorexia, frightening easily, sighing, feeling sad, *han* (a Korean cultural term related to sad sentiment, hard life and social unfairness resulting not only from the tragic collective national history but also from a traumatic personal life), racing thoughts, anxiety with agitation, and feeling guilty. Respondents are asked to indicate to what extent they agree or disagree with statements such as "My life seems unhappy" or "I regret how I spent my life" with responses ranging from strongly disagree (0) to strongly agree (3), with higher scores representing higher likelihood of having HB. Total scores ranged from 0 – 45. (Kim et al., 2008). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.86).

**Formal Resource Utilization**

Participants were asked to identify which mental health specialist(s) they went to, to help cope with mental distress within the past 12 months. The list of options were 1) primary care physician, 2) psychiatrist, 3) psychologist, 4) marriage family therapist, 5) social worker, 6) other, 7) none of the above, 8) did not go. In the survey, the options "none of the above" and "did not go" were merged. Since the last option did not differentiate if they sought professional mental health services or not, the answers were compared and matched with the question "In the past year, have you visited a mental health specialist" (yes/no) to divide and adjust the responses into "none of the above" and "did not go".

**Informal Resource Utilization**

Participants were to check off a list of how they personally coped with mental distress within the past 12 months. The list of options were 1) dealt with it myself, 2) prayed, 3) talked to my pastor/spiritual leader, 4) talked to family and friends, 5) used traditional healing, 6) ignored it, 7) exercised, and 8) other. Items were 1, 2, 5, 6, 7, and 8 were collapsed into the "individual coping methods" variable and dummy coded into (0) none and (1) used at least one. Items 3 and 4 were collapsed into the "talking to others" variable and coded (2) none and (4) used at least one. The "solitary coping methods" and "talking to others" variable were then collapsed to create the Informal Resource Utilization variable, coded (0) none, (1) individual, (2) talking to others, (3) used both solitary coping methods and talked to others.

## *Independent Variables*

### Acculturation

The Short Acculturation Scale for Koreans (SAS-K) consists of 12 items that measure a person's acculturation level. It has three subscales: (a) language (5 items), (b) media (3 items), and (c) ethnic-social relations (4 items) and asked question such as, "In general, what language do you speak" and "Your close friends are:". The responses are measured on a 5-point Likert-type scale, ranging from 0 points (only/all Korean) to 4 points (only English or all non-Korean). The participants' response was averaged across items (range of scores is 0 through 4). The mean score was used as an interval scale, where scores close to 4 indicate high levels of acculturation and those close to 0 indicate little acculturation with scores ranging from 0 - 48 (Choi & Reed, 2011). This scale has been validated among Korean adults and is available in Korean and English (2011). This scale demonstrated excellent  internal reliability for this sample (Cronbach's alpha = 0.94).

### Attitudes Toward Mental Health Services

The 10 –item version of the 29-item *Attitudes toward Seeking Professional Mental Psychological Help Scale* (Fischer & Farina, 1995) assesses an individual's openness and willingness to using professional mental health services. Respondents are asked to rate each statement using a range from 0 (disagree) to 3 (agree) to include five positive statements such as "If I believed I were having a mental breakdown, my first inclination would be to get professional attention" and five negative statements such as "The idea of talking to a psychologist strikes me as poor way to get rid of emotional

conflict". The negative responses were reversed coded and all responses were summed to get a cumulative score with higher scores representing more positive attitudes about mental health services (scores ranging from 0–30). This scale has been used to assess attitudes toward mental health services among older KAs and has been shown to have satisfactory internal consistency and is available in Korean and English (Jang, Kim, Hansen, & Chiriboga, 2007). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.73).

**Physical Health**

A single item from the Short Form Health Survey 12 (SF 12) was used to measure perceived physical health. The question asked "How would you rate your health?" with a possible response ranging from poor (0) to excellent (5) (reverse-coded) (Ware, Kosinski, & Keller, 1996).

**Religious Coping**

The Brief Religious Coping scale (Pargament, Feuille, & Burdzy, 2011) is a shortened version of the original 14-item scale. The scale used for this study is a seven-item measure of religious coping with major life stressors divided into three scales. The first scale, composed of three items, measures positive attitudes toward God, asking questions such as "I work together with God as partners to get through hard times" with responses ranging from "a great deal" (0) to "not at  all" (3) with higher scores reflecting less positive views of God. Scores ranged from 0 – 9. The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.84). The second scale, which also

includes 3 items, measures negative views of God, asking questions such as "I wonder if God has abandoned me" with answers ranging from "a great deal" (0) to "not at all" (3), with higher scores reflecting less negative views of God. Scores ranged from 0 – 9. The internal reliability fell below the acceptable range (Cronbach's alpha = 0.53). The last item in this scale measured the extent religion was involved in understanding or dealing with stressful situations, asking "To what extent is your religion involved in understanding or dealing with stressful situations in any way" with answers ranging from 0 (very involved) to 3 (not involved at all), with higher scores reflecting less involvement of religion in understanding or dealing with stressful situations.

However, for ease of scoring and interpreting the results, all 7 items in the scale were collapsed (with all items in the second scale reverse coded) to create the religious coping scale, with higher scores indicating a more positive outlook on God and more religious involvement in their decision-making. Scores ranged from 0 – 19. The Brief RCOPE scale appeared to be a good fit for KAs (Kim, Kendall, & Webb, 2015). This scale was translated into Korean by a bilingual native Korean speaker and then backtranslated into English by a bilingual native English speaker. The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.72).

**Resiliency**

The Conner-Davidson Resilience Scale (CD-RISC) scale consists of 10 items, each of which is rated by respondents on a 5-point scale (0='not true at all' to 4='true nearly all of the time') according to the extent to which they agree with each item as it applied to them over the previous month. All responses were summed to get a cumulative

score and averaged with higher mean scores reflecting greater resilience with scores

ranging from 0 – 40 (Connor & Davidson, 2003). Both the English and Korean version

have shown to be reliable and valid among Korean adults and is available in Korean and

English (Jung et al., 2012). This scale demonstrated excellent internal reliability for this

sample (Cronbach's alpha = 0.94).

**Social Support**

The Lubben Social Network Scale (LSNS) 6 (Lubben et al., 2006) is a six item

scale that is used to measure perceived social support received from family and friends.

The total score ranges from 0 – 30, with higher scores indicating more social engagement

with family and friends. The Korean revised LSNS 6 (K-LSNS-6) has been shown to

good internal reliability among Korean Americans (Hong, Casado, & Harrington, 2011).

The internal reliability for this scale was within the acceptable range (Cronbach's alpha =

0.85).

*Control Variables*

**Demographic Variables**

The respondents' gender (female/male), age, marital status (not married/married),

level of education (high school or less, some college/associate/technical training or

more), if they were employed (yes (including self-employment)/no), current occupation,

if they were able to comfortably pay their monthly bills (yes/no), place of birth (U.S.,

Korea/other), what year they moved to the U.S. if born in another country, if they have

health insurance (yes/no), insurance providers, if they have access to regular health care

(yes/no), and if they had visited a professional mental health professional within the past year (yes/no) was collected.

**Income Status**

To measure income, a proxy measure informed by Song et al. (2010) was utilized. Participants were asked in they could comfortably pay their monthly bills, responding with either yes (1) or no (0).

**Generational Status**

Participants were asked which country they were born in and what year they moved to the U.S. if born in another country. Participants that moved to the U.S. before 12 years of age or were born in the U.S. were categorized as 1.5 or 2nd generation (0) and those that were born outside of the U.S. and moved to the States after 12 years of age were categorized as 1st generation (1).

**Role in Church**

Participants were asked to select their role at church: 1) pastor, 2) pastor's wife, 3) elder, 4) deacon/deaconess, 5) member, or 6) other. This variable was then dichotomized into (0) church leaders (pastors, pastor's wives, elders, deacon/deaconess) and (1) members/others. This variable was dichotomized into church leaders (pastor, pastor's wife, elder, deacon/deaconess) (0) and church members (member, other) (1).

**Religious Affiliation**

Participants were asked to select their religious affiliation: 1) Baptist, 2) Catholic, 3) Methodist, 4) Presbyterian, 4) Seventh-day Adventist, 5) Other. This variable was dichotomized into other (0) and Seventh-day Adventist (1).

**Survey Language**

The survey was offered in both English (0) and Korean (1). Survey language was tracked on the requested language the participants took the survey.

### Data Analysis

SPSS, version 23.0 (IMP Corporation, 2014) was used for all data analyses. Before running any analyses, the data was tested for missing data, outliers and violation of assumptions. Surveys that had more than 10 percent missingness were deleted from the study. The data was also assessed to what type of missingness existed using scatterplots. Overall, missing data from the all the continuous scales had 5 percent missingness or less. It appeared that the pattern of missingness in this data set was random and therefore, mean imputation was used to address missing variables from scales (Tabachnick & Fidell, 2001).

### *Research Question 1: Scope of Distress and Protective Factors*

Frequencies and descriptives for all socio-demographic variables and anxiety, depression, hwa-byung, and stress scales were run. Further bivariate analyses with the socio-demographic variables of interest (survey language, gender, age, generation status,

and church roles) were also run with each individual distress scale items. Chi-square analyses were run to analyze group differences between dichotomous socio-demographic variables and participant's cut-off scores (below cut-off/above-cut-off) for anxiety and depression, independent samples t-tests run for assess if there were significant group differences between dichotomous socio-demographic variables and distress scores as well as protective factors, and Pearson's correlation to examine the impact of socio-demographic variables, religious coping, acculturation, resiliency, and attitudes about seeking professional mental health services on mental health status.

Hierarchal linear regression was used to build four distinct models to explore the first set of research questions pertaining to analyzing the scope of distress within the sample population. A separate model was created to predict scores for each distress scale: anxiety, depression, HB, and stress. Step 1 controlled for gender, age, and other socio-demographic variables that were significant at the bivariate level. All protective buffers significant at the bivariate level were entered in Step 2. The analyses were assessed for normal distribution of residuals (via scatterplots of errors of observed and predicted values), multicollinearity (via correlation matrix and VIF), and homoscedasticity (via scatterplot of residuals versus predicted values). The assumptions of normality of residual distribution and homoscedasticity were not violated. For independent variables that were correlated at 0.80 or higher, the variable that explained the greater amount of variance was kept and the other variable omitted from the model.

### *Research Question 2: Factors Influencing Resource Utlization*

Frequencies and descriptives for all socio-demographic variables, distress scores,

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protective buffer variables, attitude toward mental health services, and help-seeking variables were run. Chi-square analyses were run to analyze group differences between dichotomous socio-demographic variables and informal resource utilization items, independent samples t-tests run for assess if there were significant group differences between age, distress scores, protective factors, and individual coping items, and Pearson's correlation to examine the relationship of age, religious coping, acculturation, resiliency, and attitudes about seeking professional mental health services.

Hierarchal logistic regression was used to explore what factors influenced whether participants sought formal health services for mental distress. Step 1 controlled for predisposing factors that were significant at the bivariate level, significant bivariate need factors in Step 2, and interactions between need factors and enabling factors were entered in Step 3. To assess the factors that informal health service utilization, a multinomial logistic regression was run. Predisposing, need, and enabling factors that were significant at the bivariate level were included in the final model.

# CHAPTER FIVE

# ANALYZING THE SCOPE OF HWA-BYUNG, DEPRESSION, AND ANXIETY SYMPTOMS AND FACTORS IMPACTING MENTAL DISTRESS AMONG KOREAN AMERICAN CHRISTIANS IN THE GREATER LOS ANGELES AREA

Kelly Baek, MSW , Larry Ortiz, PhD, Qais Alemi, PhD, Akinchita Kumar, MSPH, and Susanne Montgomery, PhD

**Abstract**

**Background**: Mental distress and co-morbidity in the Korean-American community remains chronically high. It is critical to utilize a multi-level approach by simultaneously analyzing the occurrences of *hwa-byung* (HB), depression, and anxiety. Intersectionality was used to contextualize the unique circumstances and factors that impact mental distress.

**Methods**: Separate hierarchal linear regressions for HB, depression, and anxiety were run, controlling for socio-demographic variables in the first step and protective factors in the second step.

**Results**: Age, survey language, income, church role, generational status, and seeing a professional mental health specialist significantly predicted distress scores while higher perceived physical health and resiliency and positive views of God and/or religion appeared to serve as protective factors.

**Discussion**: Further studies should be conducted to explore to identify interventions most effective in decreasing mental distress and what interventions/resources people are most likely to use based on their unique social locations.

Key Words: Christians, *hwa-byung*, Korean-American, mental health, protective factors

## Introduction

Korean Americans (KAs) are twice as likely to report depressive symptoms than that of the general U.S. population (Bernstein, Park, Shin, Cho, & Park, 2011) but are less likely to utilize mental health services than most minority groups in the U.S. (Chin, Waters, Cook, & Huang, 2007). It was found that approximately 30-49% of first-generation KAs reported suffering from depression (Kim, 2012; Kim & Rew, 1994; Oh, Koeske, & Sales, 2002; Kim & Im, 2015), while only 17% utilized mental health services (Lee, Han, Huh, Kim, & Kim, 2014; Kim, & Im, 2015). Other studies indicate that prevalence rates for depression as high as 20-54% among older KAs (Kang, Basham & Kim, 2013; Kim, Sangalang & Kihl, 2012; Lee & Hadeed, 2009; Roh, Lee, Lee, Shibusawa & Yoo, 2014; Sin et al., 2011). Koh's study (2018) on the prevalence and predictors of depression and anxiety among KAs showed that 18.2% of the sample had severe symptoms for depression and 16.9% for anxiety.

The multiple layers of stressors that KAs face can lead to a cultural mental disorder called *hwa-byung* (HB). Literally meaning "anger disease" or "fire disease", it is a culture related syndrome related to chronic, unresolved and suppressed anger in Korea (DSM-IV; American Psychiatric Association, 1994) and is primarily identified as a Korean women's illness (Min, Suh, & Song, 2009; Lee et al., 2012). While the sufferer eventually expresses their rage and anger, it does not improve (or even worsens) the situation that caused the anger, creating a cycle of frustration at failing to change or situation in addition to failing to release the anger, eventually leading to somatic symptoms (Min, Suh, & Song, 2009). Most patients with HB have multiple diagnoses, the most common comorbidities being depressive disorders, atypical somatization

disorder, and Generalized Anxiety Disorder (GAD) (Min & Shu, 2010). A 2012 study

examined the relationship between acculturation, the presence of HB, and Western-

influenced symptom presentation among the first and second generation Korean adults

living in the United States. The study indicated that first generation Koreans were less

likely to be acculturated and were more likely to report somatic HB like symptoms

(Moon, 2012).

There are limited studies on anxiety among the Korean population, which may be

due to the overlap of symptoms between HB and depression. All the major symptoms for

GAD are found in the symptomology of HB. In addition, anxiety may not be perceived to

be a mental illness. Rather, it may be perceived as a part of normal, everyday life. The

normalization of anxiety and stress masks the significant negative impact and scope of

distress on mental well-being in the community.

## Impact of Mental Health Challenges on Korean Churches

More than 70% of KAs identify as Christian (PEW Research Center, 2012) and Korean

churches act as pillars of support for the KA community and are often the access point for

resources for spiritual, physical, and mental health needs (Chong & Gul, 1991; Kim &

Kim, 2001) Church involvement not only provides fellowship and a way to maintain

cultural ties, but can also improve social status for adults (Min, 1992; Chai, 2001; Chong

& Gul, 1991; Kim & Kim, 2001). Church leaders, particularly pastors, are often

perceived as the first line of support when community members seek help for social,

financial, and mental health challenges (Chong & Gul, 1991). However, while they may

have more access and awareness about mental health issues, church leaders themselves

arguably has more limitations on accessing services when faced with their own personal struggles, believing that if they are open with their mental health struggles, it could harm their trustworthiness in the community and they may be perceived as incompetent. The lack of culturally sensitive resources and the stigma surrounding mental illness (Bernstein et al., 2011) increases the risk of burnout. Fear of jeopardizing not only their reputation and standing in community can create a significant barrier to seeking help for church leaders (Hyun & Shin, 2010).

## Theoretical Framework

Korean Americans conceptualize mental health holistically, in which spiritual, physical and psychological components are interwoven (Leong & Lau, 2001). Therefore, mental health conditions are perceived to be an imbalance between the body, mind, and environment (Cheung, Leung, & Cheung, 2011). In addition, when analyzing the various factors that influence mental well-being, one must also be aware of the intersections (and inequalities) of different roles. Intersectionality views how fundamental factors of inequality (i.e. race, gender, class, and sexuality) mutually define and reinforce one another (Cole, 2009). Examining the intersection of roles can help gain insight on how mental distress is expressed.

While KA women were more likely to be diagnosed with mental health issues (Chun, Khang, Kim, & Cho, 2008), KA men were more likely to be diagnosed with Major Depressive Disorder (MDD) than any other group of Asian American (AA) males (Kuo, 1984). Moreover, in a culture where mental health help seeking is stigmatized (Shin, 2002), KA men are reported to engage in self-treatment for depression and other

mental health issues resulting in high rates of alcohol abuse and domestic violence against women (Duranceaux et al., 2008). Women in the KA community remain silent, reflecting the fear of breaking racial solidarity and pressure to maintain an image of strong family bonds, high educational attainment, wealth, and privilege. However, this hides the underlying issues of very real issues of both physical and mental distress for both genders (Lee, 2009).

Other factors that may contribute to the high levels of distress among the KA community can be attributed to language barriers and work and family related stress. In addition, acculturative stressors, such as struggling to balance two cultures that are at odds with each other, may also be a major contributing factor. According to Kim, Seo, & Cain (2010) who found that preference for Korean culture was associated with depressive symptoms have lower income, and have limited English proficiency (which were also associated with higher distress rates) (Bernstein et al., 2011). A 2018 study conducted on KAs showed that perceived lack of social support were common indicators for depression and anxiety (Koh, 2018).

Therefore, the purpose of this study was to assess 1) the scope of anxiety, depression, Hwa-byung (HB), and stress symptoms, 2) differences between gender, age, acculturation, and church role in the occurrence of mental distress symptoms, 3) and if acculturation, physical health, religious coping, resiliency, and social support influenced mental distress scores.

## Methods

### *Participants and Procedures*

This data was from a cross-sectional quantitative study on KA mental health

distress and help-seeking behavior in the greater Los Angeles Area (Baek, Ortiz, Alemi,

& Montgomery, n.d.). The data was collected through a questionnaire that included

questions that asked about socio-demographic variables, mental health service utilization,

self-reported mental distress, social support, religious coping, attitudes, what they did to

personally cope with mental distress, level of acculturation, and resiliency. Participants

were recruited at Korean churches located in the great Los Angeles area (GLA). Surveys

in both English and Korean were distributed at Korean churches in the GLA. A $5

donation to the church of the participant's choice was made for each survey submitted.

Convenience and snowball sampling techniques were utilized to recruit two

hundred and forty-three participants of varying genders, ages, educational levels, and

generational status. The inclusion criteria for this phase of the study entailed (a) 18 years

of age or older, (b) of Korean ancestry, and c) attend a Korean church in the GLA. The

data was collected from November 2017 to February 2018. The study was approved by

the Loma Linda University IRB.

### *Measures*

**Dependent Variables**

*Anxiety and Depression*

The Hopkins Symptoms Checklist (HSCL) 10 is a 10-item self-report symptom

inventory with the first four questions measuring symptoms of anxiety and the last six

questions measuring depression (Derogatis, Lipman, Rikels, Uhlenhuth, & Covi,1974).

Responses for each question are based on a 4 point Likert Scale (1 – not at all to 4 –

extremely) with higher scores (ranging from 4-16 for anxiety and 6-24 for depression)

indicating more emotional distress. The international cut-off score of 1.75, which

represents the boundary between what is "normal" and falls within the "clinical range"

for symptomatic depression and symptomatic anxiety, was used. This scale validated

among Korean-Americans (Cheung, Leung, & Cheung, 2011). The internal reliability for

anxiety (Cronbach's alpha = 0.81) and depression (Cronbach's alpha = 0.75) were within

the acceptable range.

### *Hwa-byung*

The Hwa-byung Scale (HB Scale) consists of 15 most common symptoms

frequency shown by individuals with self-labeled HB. Respondents were asked to

indicate to what extent they agreed or disagreed with statements such as "My life seems

unhappy" or "I regret how I spent my life" with responses ranging from strongly disagree

(0) to strongly agree (3), with higher scores representing higher likelihood of having HB

(Min, Suh, & Song, 2009). Scores ranged from 0 – 45. The internal reliability for this

scale was within the acceptable range (Cronbach's alpha = 0.86).

### Protective Factors

### *Acculturation*

The Short Acculturation Scale for Koreans (SAS-K) consists of 12 items that

measure a person's acculturation level. It has three subscales: (a) language (5 items), (b)

media (3 items), and (c) ethnic-social relations (4 items). The responses are measured on a 5-point Likert-type scale, ranging from 0 points (only Korean) to 4 points (only English). The responses provided by each respondent were averaged across items (range of scores is 0 through 4) and scores ranged from 0 – 48 with higher scores indicating higher levels of acculturation. This scale has been validated among Korean adults (Choi & Reed, 2011). The internal reliability for this scale was excellent (Cronbach's alpha = 0.94).

### *Attitudes Toward Mental Health Services*

The 10 –item version of the 29-item Attitudes toward Seeking Professional Mental Psychological Help Scale (Fisher & Farina, 1995) assesses an individuals openness and willingness to using professional mental health services. Respondents are asked to rate each statement using a range from 0 (disagree) to 3 (agree) to five positive statements such as "If I believed I was having a mental breakdown, my first inclination would be to get professional attention" and five negative statements such as "The idea of talking to a psychologist strikes me as poor way to get rid of emotional conflict". The negative responses were reversed coded and then all responses summed to get a cumulative score and averaged with higher scores representing more positive attitudes about mental health services with scores ranging from 0 - 30. This scale has been used to assess attitudes toward mental health services among older KAs and has been shown to have satisfactory internal consistency and is available in Korean and English (Jang, Kim, Hansen, & Chiriboga, 2007). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.73).

*Physical Health*

A single item from the Short Form Health Survey 12 (SF 12) was used to measure perceived physical health. The question asked "How would you rate your health?" with a possible response ranging from poor (0) to excellent (5) (reverse-coded) (Ware, Kosinski, & Keller, 1996).

*Religious Coping*

The Brief Religious Coping scale (Pargament, Feuille, & Burdzy, 2011) is a seven-item measure of religious coping with major life stressors divided into three scales. The first scale, composed of three items, measures positive attitudes toward God, the second scale, which also includes 3 items, measures negative views of God, and the last item in this scale measured the extent religion was involved in understanding or dealing with stressful situations, with answers ranging from 0 (very involved) to 3 (not involved at all), with higher scores reflecting less involvement of religion in understanding or dealing with stressful situations. While the scale is typically scored individual by the aforementioned subgroups, for this analysis all 7 items in the scale were collapsed (with all items in the second scale reverse coded) to create the religious coping scale, with higher scores indicating a more positive outlook on God and more religious involvement in their decision-making. Scores ranged from 0 – 19. The Brief RCOPE scale appeared to be a good fit for KAs (Kim, Kendall, & Webb, 2015). This scale was translated into Korean by a bilingual native Korean speaker and then backtranslated into English by a bilingual native English speaker. The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.72).

*Resiliency*

The Conner-Davidson Resilience Scale (CD-RISC) scale consists of 10 items, each of which is rated by respondents on a 5-point scale (0='not true at all' to 4='true nearly all of the time') according to the extent to which they agree with each item as it applied to them over the previous month. All responses were summed to get a cumulative score and averaged with higher scores reflecting greater resilience with scores ranging from 0 – 40 (Connor & Davidson, 2003). Both the English and Korean version have shown to be reliable and valid among Korean adults and is available in Korean and English (Jung et al., 2012). This scale demonstrated excellent internal reliability for this sample (Cronbach's alpha = 0.94).

*Social Support*

The Lubben Social Network Scale (LSNS) 6 (Lubben et al., 2006) is a six item scale that is used to measure perceived social support received from family and friends. The total score ranges from 0 – 30, with higher scores indicating more social engagement with family and friends. The Korean revised LSNS 6 (K-LSNS-6) has been shown to good internal reliability among KAs (Hong, Casado, & Harrington, 2011). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.85).

**Control Variables**

*Demographic Variables*

The respondents' gender (female/male), age, marital status (not married/married), level of education (high school or less, some college/associate/technical training or

more), if they were employed (yes (including self-employment)/no), if they have access to regular health care (yes/no), and if they had visited a professional mental health professional within the past 12 months (yes/no) was collected.

### *Income Status*

To measure income, a proxy measure informed by Song et al. (2010) was utilized. Participants were asked in they could comfortably pay their monthly bills, responding with either yes (1) or no (0).

### *Generational Status*

Participants were asked which country they were born in and what year they moved to the U.S. if born in another country. Participants that moved to the U.S. before 12 years of age or were born in the U.S. were categorized as 1.5 or $2^{nd}$ generation (0) and those that were born outside of the U.S. and moved to the States after 12 years of age were categorized as $1^{st}$ generation (1).

### *Role in Church*

Participants were asked to select their role at church: 1) pastor, 2) pastor's wife, 3) elder, 4) deacon/deaconess, 5) member, or 6) other. This variable was then dichotomized into (0) church leaders (pastors, pastor's wives, elders, deacon/deaconess) and (1) members/others. This variable was dichotomized into church leaders (pastor, pastor's wife, elder, deacon/deaconess) (0) and church members (member, other) (1).

*Religious Affiliation*

Participants were asked to select their religious affiliation: 1) Baptist, 2) Catholic, 3) Methodist, 4) Presbyterian, 4) Seventh-day Adventist, 5) Other. This variable was dichotomized into Other (0) and Seventh-day Adventist (1).

*Survey Language*

The survey was offered in both English (0) and Korean (1). Survey language was tracked on the requested language the participants took the survey.

**Data Analysis**

SPSS, version 23.0 (IBM Corporation, 2014) was used for all data analyses. Prior to conducting any analyses, data was tested for missing data, outliers, and violation of any assumptions. Any surveys that had more than 10 percent missingness were deleted from the study. Data was assessed to what type of missingness existed via scatterplots. Missing data from the continuous scales had 5 percent missingness or less. It appeared that the pattern of missingness in this data set was random and therefore, mean imputation was used to address missing variables from scales (Tabachnick & Fidell, 2001).

Frequencies and descriptives for all socio-demographic variables and protective factors for each distress scale were run. Hierarchal linear regression was used to build three distinct models to explore the first set of research questions pertaining to analyzing the scope of distress within the sample population with step 1 controlling for gender, age, and other socio-demographic variables that were significant at the bivariate level and step

2 including all protective buffers significant at the bivariate level. The analyses were

assessed for normal distribution of residuals (via scatterplots of errors of observed and

predicted values), multicollinearity (via correlation matrix and VIF), and

homoscedasticity (via scatterplot of residuals versus predicted values). The assumptions

of normality of residual distribution and homoscedasticity were not violated. For

independent variables that were correlated at 0.80 or higher, the variable that explained

the greater amount of variance was kept and the other variable omitted from the model.

### Results

#### *Participant's Characteristics*

The majority of the respondents were female, married, highly educated and 1st

generation. There was a wide range of ages, averaging around 50 years with most of the

respondents employed and able to comfortably pay their monthly bills. They were also

likely to have health insurance and regular access to health care. However less than 15%

of respondents reported that they had visited a mental health specialist in the past 12

months. Almost half of the respondents identified as church leaders and the majority of

the sample were Seventh-day Adventist. See table below for sociodemographic

characteristics.

**Table 1.** Sociodemographic characteristics (*N*=243).

| Variables | *n* (%) |
|---|---|
| Survey Language | |
|    English | 116 (47.7%) |
|    Korean | 127 (52.3%) |
| Gender | |
|    Female | 145 (59.9%) |
|    Male | 96 (39.6%) |
| Age, mean (*SD*), in years | 47.92 (19.71) |
| Marital Status | |
|    Not Married | 100 (41.2%) |
|    Married | 143 (58.8%) |
| Education | |
|    High School or less | 24 (10.4%) |
|    Some College or More | 48 (20.8%) |
| Employment | |
|    Employed | 117 (49.0%) |
|    Not Employed | 77(32.2%) |
| Income | |
|    Comfortable | 183 (79.6%) |
|    Not comfortable | 47 (20.4%) |
| Generational Status | |
|    1st Generation | 143 (58.8%) |
|    1.5/2nd Generation | 100 (41.2%) |
| Insurance | |
|    Yes | 208 (87.8%) |
|    No | 29 (12.2%) |
| Access to care | |
|    Yes | 190 (80.9%) |
|    No | 45 (19.1%) |
| Used MHS[1] | |
|    Yes | 37 (15.2%) |
|    No | 206 (84.8%) |
| Church Role | |
|    Church Leader | 110(45.3%) |
|    Church Member/Other | 133(54.7%) |
| Religion | |
|    Non Seventh-day Adventist | 83 (34.2%) |
|    Seventh-day Adventist | 160 (65.8%) |

Note. [1]MHS= Mental Health Services

**Descriptive Analyses**

Descriptive analyses were run to assess the scope of distress symptoms. The average score for Hwa-byung was 11.88 ($SD = 7.32$) with scores ranging from $0 - 37$. While there is no clinical cut-off score for the HB scale, over 20% of the respondents agreed that they felt "sad or resentful" of how they life turned out, that life was unfair/unjust, or had feelings of unfairness, felt "a rising their chest" when they got angry, felt remorseful, regretted how they spent their lives, felt frequently disappointed in themselves, and generally felt very tired. The mean score for depression was 10.07 ($SD = 2.88$) with scores ranging from $6 - 20$. The most frequent occurrences those that selected "quite a lot" or "extremely" for depression were sleep difficulties (15%), blaming oneself (20%), and feeling that everything was an effort (25%). Anxiety scores ranged from $4 - 12$, with a mean score of 6.19 ($SD=2.11$). Using the international cut-off score of 1.75 for the Hopkins Symptoms Checklist for anxiety and depression, 30.5% of the sample population scored above the cut-off score for anxiety and 43.2% for depression.

Bivariate results showed that there were no significant differences between gender, marital status, level of education, employment status, if they had insurance or not, if they had access to regular care, and religious affiliation for distress scores. However, respondents that reported that they were not able to comfortably pay their monthly bills, were 1st generation, and had seen a professional mental health specialist within the past 12 months had significantly higher Hwa-byung scores than those that were able to comfortably pay their monthly bills, 1.5/2nd generation, and did not see a professional mental health specialist in the past 12 months. In addition, those that were older, were not able to comfortably pay their monthly bills, and were church members reported

significantly higher depression scores. Anxiety scores were significantly higher for respondents that took the survey in Korean, were 1<sup>st</sup> generation, and had seen a professional mental health specialist in the past 12 months.

While there was no significant relationship between level of acculturation and attitudes toward professional mental health services and the distress scores, physical health, religious coping, resiliency, and social support were negatively related to distress scores. In addition, all distress variables were positively correlated with each other. See below for bivariate results.

**Table 2.** Categorical variables and distress variables measured at the bivariate level (*N*=243).

| Variables | Hwa-byung | | Depression | | Anxiety | |
|---|---|---|---|---|---|---|
| | *m*(*sd*) | *t* or *r* | *m*(*sd*) | *t* or *r* | *m*(*sd*) | *t* or *r* |
| Survey Language | | | | | | |
| English | 11.00(6.37) | -1.81 | 10.08(2.50) | 0.06 | 5.72(1.81) | -3.39** |
| Korean | 12.68(8.04) | | 10.06(3.20) | | 6.61(2.28) | |
| Gender | | | | | | |
| Female | 11.74(7.26) | -0.39 | 10.16(2.75) | 0.55 | 6.36(2.14) | 1.52 |
| Male | 12.11(7.49) | | 9.95(3.09) | | 5.95(2.05) | |
| Marital Status | | | | | | |
| Not Married | 11.67(7.51) | -0.37 | 10.39(2.89) | 1.47 | 5.89(1.95) | -1.90 |
| Married | 12.0 (7.21) | | 9.84(2.86) | | 6.40(2.20) | |
| Education | | | | | | |
| High School or less | 12.21(10.13) | 0.15 | 9.38(3.54) | -1.30 | 6.34(2.26) | 0.44 |
| Some College or more | 11.88(6.90) | | 10.17(2.77) | | 6.18(2.07) | |
| Employed | | | | | | |
| Yes | 11.61(7.26) | -0.72 | 9.82(2.68) | -1.40 | 6.00(1.88) | -1.41 |
| No | 12.30(7.46) | | 10.34(3.04) | | 6.38(2.27) | |
| Income[1] | | | | | | |
| Yes | 11.28(6.98) | -2.96** | 9.92(2.66) | -2.50* | 6.17(2.10) | -1.22 |
| No | 14.79(8.12) | | 11.09(3.47) | | 6.60(2.15) | |
| Generational Status | | | | | | |
| 1st Gen | 10.63(6.64) | -2.30* | 10.19(2.91) | 0.56 | 5.83(1.95) | -2.24* |
| 1.5/2nd Gen | 12.75(7.67) | | 9.98(2.87) | | 6.44(2.18) | |
| Insurance | | | | | | |
| Yes | 11.93(7.43) | -0.31 | 10.00(2.83) | -0.77 | 6.23(2.16) | 0.29 |
| No | 12.38(6.52) | | 10.45(3.33) | | 6.10(1.80) | |
| Access to care | | | | | | |
| Yes | 11.73(7.60) | -0.93 | 10.08(2.96) | -0.06 | 6.21(2.13) | -0.16 |
| No | 12.85(6.16) | | 10.11(2.55) | | 6.26(2.05) | |
| Used MHS[2] | | | | | | |
| Yes | 14.62(9.29) | 2.00* | 10.59(3.13) | 1.12 | 7.19(2.15) | 3.08** |
| No | 11.41(6.88) | | 10.02(2.84) | | 6.05(2.06) | |
| Church Role | | | | | | |
| Leader | 11.48(7.42) | -0.76 | 9.56(2.88) | -2.50* | 6.24(2.21) | 0.32 |
| Member/Other | 12.20(7.25) | | 10.48(2.82) | | 6.15(2.03) | |
| Religion | | | | | | |
| Non SDA[3] | 12.13(7.04) | 0.39 | 10.12(2.66) | 0.21 | 6.52(2.09) | 1.76 |
| SDA[3] | 11.74(7.48) | | 10.04(3.00) | | 6.02(2.11) | |

*Note.* *p* < .05; ** *p* < .01; *** *p* < .001; [1]Income = able to comfortably pay monthly bills; [2]MHS = Mental Health Services; [3]SDA = Seventh-day Adventist

**Table 3.** Correlations between age, mental distress, and protective buffers ($N = 243$).

| | M(SD) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 Age (19-90) | 47.92 (19.71) | - | | | | | | | | |
| 2 Anxiety (4-16) | 6.19 (2.11) | 0.19** | - | | | | | | | |
| 3 Depression (6-24) | 10.07 (2.88) | -0.01 | 0.64** | - | | | | | | |
| 4 Hwa-byung (0-45) | 11.88 (7.32) | 0.05 | 0.63*** | 0.70** | - | | | | | |
| 5 Acculturation (0-44) | 16.41 (10.28) | (-)0.63*** | -0.1 | 0.06 | -0.6 | - | | | | |
| 6 Attitudes Toward MHS[1] (0-30) | 21.58 (5.53) | (-)0.18** | 0.1 | 0 | 0 | 0.19** | - | | | |
| 7 Health (0-5) | 3.22 (1.00) | -0.5 | (-)0.42*** | (-)0.32** | (-)0.46*** | 0.16* | (-)0.18** | - | | |
| 8 Religious Coping (0-21) | 20.18 (3.52) | 0.09 | -0.1 | (-)0.28*** | (-)0.35*** | -0.04 | -0.04 | 0.12 | - | |
| 9 Resiliency (0-40) | 28.05 (6.98) | -0.07 | (-)0.33*** | (-)0.37*** | (-)0.47*** | 0.09 | -0.05 | 0.32*** | 0.25*** | - |
| 10 Social Support (0-30) | 18.29 (5.53) | -0.1 | (-)0.13* | (-)0.17** | (-)0.16* | 0.16* | 0.03 | 0.18** | 0.05 | 0.24*** |

*Note:* * $p < .05$; ** $p < .01$; *** $p < .001$; [1]MHS=Mental Health Services

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**Multivariate Analyses**

*Hwa-byung*

A Hiearchal Linear Regression (HLR) was used to determine the influence of perceived physical health status, religious coping, resiliency and social support on hwa-byung, controlling for gender, age, income, generational status, and if they had seen a professional mental health specialist. Regression analyses showed that variables entered in Step 1 significantly predicted HB scores, $R^2 = 0.08$, $R^2_{adjusted} = 0.06$, $F(5, 217) = 3.82$, $p < .001$) with income ($\beta = 0.19$, $p < .01$) and generational status ($\beta = 0.18$, $p < .05$) significantly contributing to the model. Step 2 shows that after controlling for socio-demographic variables, health, religious coping, and resiliency added significantly ($\Delta R^2 = 0.34$, $p < .001$) to the model predicting HB scores ($R^2 = 0.43$, $R^2_{adjusted} = 0.41$, $F(9, 213) = 17.48$, $p < .001$), explaining 34.0% of the variance with generational status remaining significant in Step 2 (remained significant in Step 2 ($\beta = 0.14$, $p < .05$). Physical health ($\beta = -0.32$, $p < .001$) and resiliency ($\beta = -0.31$, $p < .001$) exerted the strongest effect with religious coping ($\beta = -0.24$, $p < .001$) last. However, social support did not significantly contribute to the model.

**Table 4.** Hierarchical linear regression model predicting *hwa-byung* scores (*n=223*).

| | Step 1*** | Step 2*** |
|---|---|---|
| | *β* | *β* |
| Gender | 0.02 | 0.08 |
| Age | -0.03 | -0.02 |
| Income | 0.19** | 0.08 |
| Generation | 0.18* | 0.14* |
| Used MHS[1] | -0.12 | -0.06 |
| Health | | -0.32*** |
| Religious Coping | | -0.24*** |
| Resiliency | | -0.31*** |
| Social Support | | 0.00 |
| $R^2$ | 0.08 | 0.43 |
| Adjusted $R^2$ | 0.06 | 0.41 |
| $\Delta R^2$ | 0.08 | 0.34 |
| *F-statistic* | 3.82 | 17.48 |

*Note.* \**p* < .05; \*\**p* < .00; \*\*\**p* < .001;
[1]MHS= Mental Health Services

### *Depression*

To determine the influence of perceived physical health status, religious coping, resiliency and social support on depression, controlling for gender, age, income and role in church a HRL was run. Regression analyses showed that variables entered in Step 1 significantly predicted depression scores, $R^2 = 0.05$, $R^2_{adjusted} = 0.04$, $F(4, 220) = 3.13$, $p <$ .05) with income ($\beta = 0.15$, $p < .05$) and church role ($\beta = 0.16$, $p < .05$) significantly contributing to the model. Step 2 shows that after controlling for socio-demographic variables, health, religious coping, and resiliency added significantly ($\Delta R^2 = 0.17$, $p <$ .001) to the model predicting depression scores ($R^2 = 0.22$, $R^2_{adjusted} = 0.20$, $F(8, 216) =$ 11.80, $p < .001$), explaining 17.0% of the variance. None of the sociodemographic

variables remained significant in Step 2. Resiliency exerted the strongest effect ($\beta$ = -0.22, $p$ < .01) with health status ($\beta$ = -0.19, $p$ < .01) and religious coping ($\beta$ = -0.19, $p$ < .01) having an equal effect. However, social support did not significantly contribute to the model.

**Table 5**. Hierarchical linear regression model predicting depression scores (n=225).

|  | Step 1* | Step 2*** |
|---|---|---|
|  | $\beta$ | $\beta$ |
| Gender | -0.04 | -0.01 |
| Age | 0.08 | 0.03 |
| Income | 0.15* | 0.08 |
| Church Role | 0.16* | 0.08 |
| Health |  | -0.19** |
| Religious Coping |  | -0.19** |
| Resiliency |  | -0.22** |
| Social Support |  | -0.02 |
| $R^2$ | 0.05 | 0.22 |
| Adjusted $R^2$ | 0.04 | 0.20 |
| $\Delta R^2$ | 0.05 | 0.17 |
| *F-statistic* | 3.13 | 7.77 |

*Note. *p* < .05; **p* < .00; ***p* < .001*

### *Anxiety*

A HLR was used to determine the influence of perceived physical health status, resiliency and social support on anxiety, controlling for gender, survey language, generational status, and if they had seen a mental health specialist within the past 12 months. Age was not included due to multicollinearity with survey language. Regression analyses showed that variables entered in Step 1 significantly predicted anxiety scores, $R^2$

$= 0.10$, $R^2_{adjusted} = 0.08$, $F(5, 226) = 4.76$, $p < .001$) with seeing a mental health specialist ($\beta = -0.18$, $p < .01$) significantly contributing to the model. Step 2 shows that after controlling for socio-demographic variables, health and resiliency added significantly ($\Delta R^2 = 0.18$, $p < .001$) to the model predicting anxiety scores ($R^2 = 0.28$, $R^2_{adjusted} = 0.25$, $F(8, 223) = 10.79$, $p < .001$), explaining 18.4% of the variance in anxiety scores. Seeing a professional mental health specialist was still significant in Step 2 ($\beta = -0.13$, $p < .05$). Health status exerted the strongest effect ($\beta = -0.34$, $p < .001$) with resilience second ($\beta = -.20$, $p < .01$). However, social support did not significantly contribute to the model.

**Table 6**. Hierarchical linear regression model predicting anxiety scores (*n*=238).

|  | Step 1*** | Step 2*** |
|---|---|---|
|  | *β* | *β* |
| Gender | -0.07 | -0.02 |
| Language | 0.19* | 0.14 |
| Generation | 0.03 | 0.03 |
| Used MHS[1] | -0.17** | -0.13* |
| Health |  | -0.33*** |
| Resiliency |  | -0.20** |
| Social Support |  | -0.01 |
| $R^2$ | 0.09 | 0.08 |
| Adjusted $R^2$ | 0.28 | 0.26 |
| $\Delta R^2$ | 0.09 | 0.19 |
| *F-statistic* | 5.85 | 12.69 |

*Note.* \*$p < .05$; \*\*$p < .00$; \*\*\*$p < .001$;
[1]MHS= Mental Health Services

**Discussion**

The purpose of this study was to explore the scope of *hwa-byung*, depression, and anxiety and to assess if there were differences in levels of distress in regard to a number

of risk- and protective buffers. The lack of group differences for gender across all mental distress occurrences may be due to the overall high levels of HB, depression, and anxiety. While hwa-byung is typically associated with older, low-income women (Min, Suh, & Song, 2009; Lee, Min, Kim, Cho, Lee, et al., 2012), results indicate that the focus needs to broaden to include men and young adults. When comparing the results for depression and anxiety, the frequency of occurrences and the percentage of those that scored above the international cut-off score were very similar for both genders.

Those that were first generation and took the survey in Korean were more likely to have higher HB or anxiety scores, providing support that these types of distress is linked to language proficiency (Bernstein et al., 2011). There was also a positive relationship with seeking mental health services and higher HB and anxiety scores, which may be due to an increase in awareness about one's level of distress or a diagnosis as a result of seeking treatment.

There was an inverse relationship between income and depression and HB with those who were not able to comfortably pay their monthly bills more likely to report higher distress scores, matching the results from prior studies on depression (Bernstein et al., 2011) and HB (Lee et al., 2012).

However, those who identified as church members were also more likely to have higher depression scores, conflicting with the hypothesis that church leaders would be more likely to be distressed. This may be due to the potential protective buffer that positive religious coping has on depression. An independent samples t-test revealed that church leaders had significantly more positive views of God and religion ($M$= 20.91, $SD$=2.89) than church members ($M$= 19.58, $SD$=3.88), ($t$[238]= 3.06, $p < .01$).

As observed in Leong & Lau (2001) and Cheung, Leung, & Cheung's studies (2011), the relationship between physical health, resiliency, views of God and religion, and mental health reflects the holistic view of the body in which the physical, spiritual, and mental are explicably interwoven. This provides support that health, resiliency, and religiosity can potentially act as protective buffers for distress in the KA community and suggest that all three aspects be incorporated when developing culturally appropriate resources and interventions.

### *Limitations*

This study focused only on recruiting at churches in the greater Los Angeles area and the information gleaned in this study can only be generalized to similar population groups. Due to the importance of networking in Korean culture, the researcher had limited success in finding participants in which she had no personal connections and heavily relied on convenience or snowball sampling. However, the recruited sample was a diverse group of community participants from varying educational and employment background, religious affiliation, generational status, age and gender. Also, it is important to note that outcomes were determined and analyses were conducted cross-sectionally, therefore a true cause-effect relationship cannot be established.

Also, while this study used intersectionality as the theoretical framework, to be able to statistically represent the various intersections of roles, it is suggested that a multiplicative approach be utilized (Veenstra, 2013) rather than an additive analysis that was used in this study. However, in order to run the analyses using the multiplicative approach, it calls for a significantly larger sample size than the researcher was able to

collect given the time and resource restraints. It is suggested that this study be replicated in the future with the minimum required sample size. In addition, there were significant limitations when quantitatively analyzing intersectionality.

## Conclusion

Overall, the results from this study provide support for the need to provide resources and support that reflect the unique circumstances and diverse social identities and locations KA community members. The potentially positive effects that health status, resiliency, more positive views of God and religion have on lowering the occurrences of distress symptoms should be further explored. It is suggested that future studies be conducted to further explore which types of interventions would be most effective in not only decreasing mental distress but also in identifying interventions or resources people are most likely to use based on their unique social locations that influence mental distress.

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# CHAPTER SIX

# FACTORS INFLUENCING FORMAL AND INFORMAL RESOURCE

# UTILIZATION FOR MENTAL DISTRESS AMONG KOREAN AMERICAN

# CHRISTIANS IN THE GREATER LOS ANGELES AREA

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**Abstract**

**Background**: While there are persistently high rates of mental distress in this community, Korean-Americans (KAs) continue to have significantly lower rates of professional mental health utilization than the general population in the U.S. making it increasingly critical to study factors that impact resource utilization.

**Methods**: Using Anderson's Healthcare Utilization Model, factors that influence the use of formal and informal resource utilization for mental distress among KAs were examined.

**Results**:  Level of education, employment status, and religious affiliation significantly predicted professional health service utilization. Informal resource utilization was significantly influenced by gender, attitudes toward professional mental health services, acculturation, and views of God and religion.

**Discussion**: It is suggested that future studies be conducted to further explore which types of interventions would be most effective in not only decreasing mental distress but also in identifying interventions or resources people are most likely to use based on their unique intersections.

**Key Words**: Anderson Healthcare Utilization Model, Christians, Korean-American, mental health, resource utilization

## Introduction

While there are persistently high rates of mental distress in this community (Bernstein, Park, Shin, Cho, & Park, 2011; Gee, Ro, Shariff-Marco, & Chae, 2009; Hurh, 1998; Kim, Park, Storr, Tran, & Joun, 2015), Korean-Americans (KAs) continue to have significantly lower rates of professional mental health utilization than other ethnic groups (Chin, Waters, Cook, & Huang, 2007; Gee, Ro, Shariff-Marco, & Chae, 2009; Ryu, Young, & Park, 2001). However, there is the essentialist notion that all Asians are the same disregards the issues or the diverse experiences within the Asian American (AA) communities, justifying the lack of policies that recognizes the diversity in the AA community and scarcity of culturally sensitive resources to meet the unique needs of each ethnic group, such as the KA community (Hurh, 1998; Chen, Sullivan, Lu, & Tazuko, 2003; Shin, 2010). As one of the fastest growing Asian ethnic subgroups in the United States (U.S. Census Bureau, 2010), it is becoming increasingly critical to utilize a multi-level framework to study factors that impact help-seeking behavior among KAs.

The Anderson Healthcare Utilization Model (AHUM) is based on the assumption that there are three major factors that influence resource utilization: 1) predisposing factors (i.e. race, age, health beliefs, culture), 2) enabling factors (i.e. family support, access to care) and 3) need (the perceived and actual need for resources) (Anderson, 1968). Utilizing this model allows us to contextualize multiple aspects that impact professional help-seeking behavior and type of informal coping methods. This provides information for both formal and informal sources of support and ways to allocate resources to effectively address the rates of distress in the KA community.

## Predisposing Factors

Asian worldviews on the dynamics between the mind and the body tend to be more holistic, in which psychological and physical problems are inseparable and psychological disorders are biological in nature (Leong & Lau, 2001). Koreans also perceive mental health conditions to be a lack of balance between their body, mind, and environment (Cheung, Leung, & Cheung, 2011) and are thus more likely to seek help for psychological distress from a physician than a mental health professional. There is also the belief that mental health conditions are hereditary and shameful not only to themselves but also to their families (Jang, Chiriboga, & Okazaki, 2007). Adverse mental health experiences may also be perceived as an indication of personal weakness, which contribute to the cultural sigma about openly discussing mental health challenges and seeking help (Shin, 2002).

Gender also appeared to play a role with KA women are significantly more distressed than KA men as found in Chun, Khang, Kim, & Cho's study (2008). Furthermore, while KA women are more likely to be distressed than men (Chun et al., 2008), KA men were more likely to be diagnosed with major depressive disorder than any other group of East Asian males (Kim, Park, Storr, Tran, & Joun, 2015). Moreover, in a culture where help seeking for mental health problems is stigmatized (Shin, 2002), KA men are reported to engage in self-treatment for depression and other mental health issues as demonstrated in studies showing high rates of alcohol abuse and domestic violence (Rhee, 1997) in addition to acculturative stress (Choi, Miller, & Wilber, 2009).

High rates of KAs without health insurance pose an additional barrier for mental health services utilization in the KA community (Ryu, Young, & Park, 2001). Policies

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that undermine the need for culturally relevant services and resources further exacerbate mental health struggles in the KA community (Gee, Ro, Shariff-Marco, & Chae, 2009).

**Enabling Factors**

KAs tend to live in or near large cities within large Korean communities, to help maintain their ethnic identities and cultural ties, with Korean churches having long served as the main source of community support and solidarity for the community (Kim, Kim, & Kelly, 2006). With approximately 71% of the Korean-American population identifying as Christian (PEW Research Center, 2012), Korean ethnic churches provide critical support and often are the networking system for Korean immigrants (Chong & Gul, 1991; Kim & Kim, 2001). Being involved in these churches not only provides fellowship with other Korean immigrants and ways to maintain Korean culture, it also a way for Korean immigrants to find social services and a significant source of social support. Church involvement can also improve social status and positions for adults (Chai, 2001; Chong & Gul, 1991; Kim & Kim, 2001). As trusted members of the community, church leaders serve as first lines of support for mental health challenges (Kim & Kim, 2001) and often serve as access points to resources outside of the community.

Bernstein et al. (2011) found that low income and limited English proficiency were also associated with high distress rates. This suggests that increasing access to care, income level, and English language proficiency may help alleviate the high rates of distress.

**Need**

Approximately 30-54% Korean-Americans suffer from depression (Bernstein et al., 2011; Kang, Basham & Kim, 2013; Kim, 2012; Kim & Im, 2015; Kim, Sangalang & Kihl, 2012; Lee & Hadeed, 2009; Roh, Lee, Lee, Shibusawa & Yoo, 2014; Sin et al., 2011) yet are less likely to seek professional mental health services to help cope with mental distress than other minority groups (Bernstein et al., 2012; Chin, Waters, Cook, & Huang, 2007). In addition, there are high levels of co-morbidities with anxiety and a cultural mental illness called hwa-byung (HB) with Koh's (2018) study showing similar rates of sever depression (18.2%) and anxiety symptoms (16.9%). There are several overlaps in symptomology between depression, anxiety, and hwa-byung. Hwa-byung is a mental disorder caused by chronically unresolved and suppressed feelings of unresolved injustice, anger and sadness which eventually manifest into somatic symptoms, such as stomach issues, fatigue, and chest pains (Min, Suh, & Song, 2009; Min & Suh, 2010). A study by Baek et al. (n.d.) also showed highly significant positive relationships between depression, anxiety, and hwa-byung scores.

**Significance of the study**

The significance of understanding factors that influence resource utilization within the KA community rest on several factors: 1) the fast growing KA population in the U.S., 2) the persistently high rate of mental distress, 3) low rate of mental health service utilization likely due the cultural stigma surrounding mental illness and the availability of culturally-sensitive mental health interventions, and 4) limited information about informal sources of support to cope with mental distress. Therefore, the purpose of

this study was to examine factors that influence the use of formal and informal resource utilization for mental distress among Korean-Americans.

## Methods

### *Participants and Procedures*

This data was from a cross-sectional quantitative study on KA mental health distress and help-seeking behavior in the greater Los Angeles Area (Baek, Ortiz, Alemi, & Montgomery, n.d.). The survey included questions that asked about socio-demographic variables, health service access and utilization, self-reported mental distress, social support, religious coping, attitudes, what they did to personally cope with mental distress, level of acculturation, and resiliency. Participants were recruited at Korean churches located in the great Los Angeles area and had the option of taking a hard copy or online survey in English or Korean. A $5 donation to the church of the participant's choice was made for each survey submitted.

A total of 243 participants of varying genders, ages, educational levels, and generational status were recruited. The inclusion criteria for this phase of the study entailed (a) being 18 years of age or older, (b) of Korean ancestry, and c) attend a Korean church in the greater Los Angeles area. The data was collected from November 2017 to February 2018. The study was approved by the Loma Linda University IRB.

<center>*Measures*</center>

**Predisposing Factors**

*Demographic Variables*

  The respondents' gender (female/male), age, marital status (not married/married), level of education (high school or less, some college/associate/technical training or more), if they were employed (yes (including self-employment)/no), current occupation, if they were able to comfortably pay their monthly bills (yes/no), place of birth (U.S., Korea/other), what year they moved to the U.S. if born in another country, if they have health insurance (yes/no), insurance providers, if they have access to regular health care (yes/no), and if they had visited a professional mental health professional within the past year (yes/no) was collected.

*Income Status*

  To measure income, a proxy measure informed by Song et al. (2010) was utilized. Participants were asked in they could comfortably pay their monthly bills, responding with either yes (1) or no (0).

*Generational Status*. Participants were asked which country they were born in and what year they moved to the U.S. if born in another country. Participants that moved to the U.S. before 12 years of age or were born in the U.S. were categorized as 1.5 or 2nd generation (0) and those that were born outside of the U.S. and moved to the States after 12 years of age were categorized as 1st generation (1).

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### Role in Church

Participants were asked to select their role at church: 1) pastor, 2) pastor's wife, 3) elder, 4) deacon/deaconess, 5) member, or 6) other. This variable was then dichotomized into (0) church leaders (pastors, pastor's wives, elders, deacon/deaconess) and (1) members/others. This variable was dichotomized into church leaders (pastor, pastor's wife, elder, deacon/deaconess) (0) and church members (member, other) (1).

### Religious Affiliation

Participants were asked to select their religious affiliation: 1) Baptist, 2) Catholic, 3) Methodist, 4) Presbyterian, 4) Seventh-day Adventist, 5) Other. This variable was dichotomized into other (0) and Seventh-day Adventist (1).

### Survey Language

The survey was offered in both English (0) and Korean (1). Survey language was tracked on the requested language the participants took the survey.

## Enabling Factors

### Acculturation

The Short Acculturation Scale for Koreans (SAS-K) consists of 12 items that measure a person's acculturation level. It has three subscales: (a) language (5 items), (b) media (3 items), and (c) ethnic-social relations (4 items). The responses are measured on a 5-point Likert-type scale, ranging from 0 points (only Korean) to 4 points (only English). The responses provided by each respondent was averaged across items (range

of scores is 0 through 4). The mean score was used as an interval scale, where scores close to 4 indicate high levels of acculturation and those close to 0 indicate little acculturation with scores ranging from 0 – 48 (Choi & Reed, 2011). This scale has been validated among Korean adults and is available in Korean and English (2011). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.94).

### *Attitudes Toward Mental Health Services*

The 10 –item version of the 29-item Attitudes toward Seeking Professional Mental Psychological Help Scale (Fisher & Farina, 1995) assesses an individuals openness and willingness to using professional mental health services. Respondents are asked to rate each statement using a range from 0 (disagree) to 3 (agree) to five positive statements such as "If I believed I was having a mental breakdown, my first inclination would be to get professional attention" and five negative statements such as "The idea of talking to a psychologist strikes me as poor way to get rid of emotional conflict". The negative responses were reversed coded and then all responses summed to get a cumulative score and averaged with higher scores representing more positive attitudes about mental health services with scores ranging from 0 - 30. This scale has been used to assess attitudes toward mental health services among older KAs and has been shown to have satisfactory internal consistency and is available in Korean and English (Jang, Kim, Hansen, & Chiriboga, 2007). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.73).

*Physical Health*

The question, "How would you rate your health?" was used to measure perceived health status with responses ranging from poor (0) to excellent (5).

*Religious Coping*

The Brief Religious Coping scale (Pargament, Feuille, & Burdzy, 2011) is a seven item measure of religious coping with major life stressors divided into three scales. The first scale, composed of three items, measures positive attitudes toward God, asking questions such as "I work together with God as partners to get through hard times" with responses ranging from "a great deal" (0) to "not at all" (3) with higher scores reflecting less positive views of God. Scores ranged from $0 - 9$. The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.84). The second scale, which also includes 3 items, measures negative views of God, asking questions such as "I wonder if God has abandoned me" with answers ranging from "a great deal" (0) to "not at all" (3), with higher scores reflecting less negative views of God. Scores ranged from $0 - 9$. The internal reliability fell below the acceptable range (Cronbach's alpha = 0.53). The last item in this scale measured the extent religion was involved in understanding or dealing with stressful situations, asking "To what extent is your religion involved in understanding or dealing with stressful situations in any way" with answers ranging from 0 (very involved) to 3 (not involved at all), with higher scores reflecting less involvement of religion in understanding or dealing with stressful situations.

However, for ease of scoring and interpreting the results, all 7 items in the scale were collapsed (with all items in the second scale reverse coded) to create the religious

coping scale, with higher scores indicating a more positive outlook on God and more religious involvement in their decision-making. Scores ranged from 0 – 19. The Brief RCOPE scale appeared to be a good fit for KAs (Kim, Kendall, & Webb, 2015). This scale was translated into Korean by a bilingual native Korean speaker and then backtranslated into English by a bilingual native English speaker. The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.72).

### *Resiliency*

The Conner-Davidson Resilience Scale (CD-RISC) scale consists of 10 items, each of which is rated by respondents on a 5-point scale (0='not true at all' to 4='true nearly all of the time') according to the extent to which they agree with each item as it applied to them over the previous month. All responses were summed to get a cumulative score and averaged with higher mean scores reflecting greater resilience with scores ranging from 0 – 40 (Connor & Davidson, 2003). Both the English and Korean version have shown to be reliable and valid among Korean adults and is available in Korean and English (Jung et al., 2012). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.91).

### *Social Support*

The Lubben Social Network Scale (LSNS) 6 (Lubben et al., 2006) is a six item scale that is used to measure perceived social support received from family and friends. The total score ranges from 0 – 30, with higher scores indicating more social engagement with family and friends. The Korean revised LSNS 6 (K-LSNS-6) has been shown to

good internal reliability among KAs (Hong, Casado, & Harrington, 2011). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.85).

**Need Factors**

*Anxiety and Depression*

The Hopkins Symptoms Checklist (HSCL) 10 is a 10-item self-report symptom inventory that measures symptoms of anxiety and depression derived from a stepwise regression analysis of the HSLC 25 item scale (Derogatis, Lipman, Rikels, Uhlenhuth, & Covi,1974). The first 4 items measure anxiety symptoms (scores ranging from 4 – 16) and the next 6 items measure depression symptoms (scores ranging from 6 – 24). Responses for each question are based on a 4 point Likert Scale (1 – not at all to 4 – extremely) with higher mean scores indicating more emotional distress. The international cut-off score of >1.75 for each subscale, which represents the boundary between what is "normal" and falls within the "clinical range" for symptomatic depression and symptomatic anxiety was used. This scale has been used to measure depressive and anxiety symptoms among KAs and is available in Korean and English (Cheung, Leung, & Cheung, 2011). The internal reliability for anxiety (Cronbach's alpha = 0.81) and depression (Cronbach's alpha = 0.75) were within the acceptable range.

*Hwa-byung*

The Hwa-byung Scale (HB Scale) consists of 15 most common symptoms frequency shown by individuals with self-labeled HB. It includes measuring constructs such as feelings of subjective anger, "*uk-wool*" and "*boon*" (a Korean culture-related

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sentiment related to social unfairness), respiratory stuffiness, going-out, insomnia, headache/pain, dry mouth, anorexia, frightening easily, sighing, sad mood, "*haan*" (a Korean culture related to sad sentiment, hard life and social unfairness resulting not only from the tragic collective national history but also from a traumatic personal life), many thoughts, anxiety with agitation, and guilty feelings. Respondents are asked to indicate to what extent they agree or disagree with statements such as "My life seems unhappy" or "I regret how I spent my life" with responses ranging from strongly disagree (0) to strongly agree (3), with higher scores representing higher likelihood of having HB (Min, Suh, & Song, 2009). The internal reliability for this scale was within the acceptable range (Cronbach's alpha = 0.86).

**Resource Utilization**

*Formal Service Utilization*

Participants were asked to identify which professional specialist(s) they went to, to help cope with mental distress within the past 12 months. The list of options were 1) primary care physician, 2) psychiatrist, 3) psychologist, 4) marriage family therapist, 5) social worker, 6) other, 7) none of the above, 8) did not go. In the survey, the options "none of the above" and "did not go" were merged. Since the last option did not differentiate if they sought professional mental health services or not, the answers were compared and matched with the question "In the past year, have you visited a mental health specialist" (yes/no) to divide and adjust the responses into "none of the above" and "did not go".

*Informal Resource Utilization*

Participants were to check off a list of how they personally coped with mental distress within the past 12 months. The list of options were 1) dealt with it myself, 2) prayed, 3) talked to my pastor/spiritual leader, 4) talked to family and friends, 5) used traditional healing, 6) ignored it, 7) exercised, and 8) other. The options were then categorized into none (0) (if they did not use any informal health service utilization methods), solitary coping methods (1) (dealt with it myself, prayed, used traditional healing, ignored it, and exercised), talk to others (2) (talked to my pastor/spiritual leader, talked to family/friends), and both (3) (used solitary coping methods and talking to others).

## Data Analyses

SPSS, version 23.0 (IMP Corporation, 2014) was used for all data analyses. Before running any analyses, the data was tested for missing data, outliers and violation of assumptions. Surveys that had more than 10 percent missingness were deleted from the study. The data was also assessed to what type of missingness existed using scatterplots. Overall, missing data from the all the continuous scales had 5 percent missingness or less. It appeared that the pattern of missingness in this data set was random and therefore, mean imputation was used to address missing variables from scales (Tabachnick & Fidell, 2001).

Frequencies and descriptives for all socio-demographic variables, distress scores, protective buffer variables, attitude toward mental health services, and help-seeking variables were run. Chi-square analyses were run to analyze group differences between

dichotomous socio-demographic variables and informal resource utilization items, independent samples t-tests run for assess if there were significant group differences between age, distress scores, protective factors, and solitary coping items, and Pearson's correlation to examine the relationship of age, religious coping, acculturation, resiliency, and attitudes about seeking professional mental health services.

Hierarchal logistic regression was used to explore what factors influenced whether participants sought formal health services for mental distress. Step 1 controlled for predisposing factors that were significant at the bivariate level, significant bivariate need factors in Step 2, and interactions between need factors and enabling factors were entered in Step 3. To assess the factors that informal health resource utilization, a multinomial logistic regression was run. Predisposing, need, and enabling factors that were significant at the bivariate level were included in the final model.

## Results

### *Participant Characteristics*

The sample population was predominantly female, married, highly educated, and $1^{st}$ generation. Ages ranged from 19 – 90 years with a mean of 47.9 years ($SD = 19.7$). Most of the respondent reported currently being employed and able to comfortably pay their monthly bills in addition to having health insurance and regular access to health care. A large majority the respondents reported that they had not visited a mental health specialist in the past 12 months. Over 65% of the sample identified as Seventh-day Adventist and there was a slightly larger percentage of church members than church leaders.

### *Bivariate Results*

The majority of the respondents indicated that they did not seek professional services for mental health challenges within the past 12 months. There were no significant group differences between survey language, gender, age, marital status, income, generational status, whether they had insurance or not, if they had access to regular health care, or church role. Enabling factors such as level of acculturation, religious coping and attitudes toward professional mental health services were not significantly related to if they used professional service to help deal with mental distress. However, those who had at least had some college or more, were employed, reported that they had seen a mental health specialist in the last 12 months, and were not Seventh-day Adventist were more likely to seek services. In addition, those that reported that they had sought professional health services for distress had higher anxiety and Hwa-byung scores and lower resiliency scores.

For informal resource utilization, the majority of the respondents only used solitary coping methods. There were slightly more respondents that used both types of resource than those that only talked to others to help deal with mental distress. There were no significant group differences for type of informal resource utilization used for level of education, employment status, income, if they had insurance, if they had access to regular care, if they had seen mental health specialist in the past 12 months, church role, or religious affiliation.

Respondents that tended to use solitary based resources were more likely to have taken the survey in Korean, be male, older, married, first generation, less acculturated, and had more negative views of professional mental health services. Specifically, an analysis of

variance showed that effect of age was significant in what types of informal health service utilization were used ($F$[3,233]= 18.29; $p < .001$). Post hoc analyses using the Tukey's LSD post hoc criterion for significance indicated that the average age was significantly lower for respondents that talked to others ($M$= 43.10,$SD$= 17.80) or used both types of resources ($M$=38.52 ,$SD$=16.60 ) than those that did not use any informal health service utilization ($M$=63.50, $SD$=17.78) or only used solitary based resources ($M$= 55.87,$SD$= 18.83). Acculturation also had a significant effect on types of informal health service utilization [$F$(3,239)= 15.02; $p < .001$], in which those that were more acculturated were more like to talk to others ($M$= 16.00, $SD$= 11.66) or use both types of resources ($M$= 21.53, $SD$= 9.26) than those that did not use any resources ($M$= 11.44, $SD$= 5.92) or only used solitary based resources ($M$= 12.77, $SD$= 9.18). Attitudes toward professional mental health services varied significantly by types of personal coping [$F$(3,239)= 3.80; $p < .05$]. Respondents who used both types of resources had significantly more positive view of professional mental health services ($M$= 22.92, $SD$= 6.17) than those that did not use any resources ($M$= 18.00, $SD$= 4.95) or only used solitary based resources ($M$= 20.86, $SD$= 5.00). See below for bivariate results.

**Table 1**. Predisposing factors and resource utilization variables (*N*= 243).

| | | $X^2$, *t,* or *F* statistic | |
| --- | --- | --- | --- |
| | *N*(%) or *M*(*SD*) | Formal Services | Informal Services |
| Survey Language | | | |
| English | 116 (47.7%) | $X^2(1)=1.00$ | $X^2(3)=46.55$*** |
| Korean | 127 (52.3%) | | |
| Gender | | | |
| Male | 96 (39.6%) | $X^2(1)=0.04$ | $X^2(3)=8.96$* |
| Female | 145 (59.9%) | | |
| Age, years (19-90) | 47.92 (*SD*=19.71) | $t(235)=-1.82$ | $F(3,233)=18.29$*** |
| Marital Status | | | |
| Not Married | 100 (41.2%) | $X^2(1)=0.00$ | $X^2(3)=17.59$** |
| Married | 143 (58.8%) | | |
| Education | | | |
| High School or less | 24 (10.4%) | $X^2(1)=9.93$** | $X^2(3)=2.09$ |
| Some College or More | 207 (89.6%) | | |
| Employment | | | |
| Employed | 117 (49.0%) | $X^2(1)=7.35$** | $X^2(3)=3.59$ |
| Not Employed | 122 (51.0%) | | |
| Income | | | |
| Comfortable | 183 (79.6%) | $X^2(1)=0.36$ | $X^2(3)=2.93$ |
| Not comfortable | 47 (20.4%) | | |
| Generation | | | |
| 1.5/2nd Generation | 100 (41.2%) | $X^2(1)=0.51$ | $X^2(3)=29.85$*** |
| 1st Generation | 143 (58.8%) | | |
| Insurance | | | |
| Yes | 208 (87.8%) | $X^2(1)=0.64$ | $X^2(3)=1.98$ |
| No | 29 (12.2%) | | |
| Access to care | | | |
| Yes | 190 (80.9%) | $X^2(1)=3.53$ | $X^2(3)=2.82$ |
| No | 45 (19.1%) | | |
| Used MHS[1] | | | |
| Yes | 37 (15.2%) | $X^2(1)=51.17$*** | $X^2(9)=11.59$ |
| No | 206 (84.8%) | | |
| Church Role | | | |
| Church Leaders | 110 (45.6%) | $X^2(1)=0.09$ | $X^2(3)=3.17$ |
| Members/Other | 131 (54.4%) | | |
| Religion | | | |
| Other | 83 (34.2%) | $X^2(1)=9.93$** | $X^2(3)=3.10$ |
| Seventh-day Adventist | 160 (65.8%) | | |

*Note*. **p* < .05; ***p* < .01; ****p* < .001; [1]MHS = Mental Health Services

**Table 2**. Need factors, enabling factors and resource utilization variables (*N*=243).

| Variable | *N*(%) or *M*(SD) | *t* or *F* statistic | |
| --- | --- | --- | --- |
| | | Formal Services | Informal Services |
| Anxiety | 6.19 (2.11) | $t(241)=-3.61$*** | $F(3,239)=2.20$ |
| Depression | 10.07 (2.88) | $t(241)=-1.81$ | $F(3,239)=2.11$ |
| Hwa-byung | 11.88 (7.32) | $t(241)=-2.92$** | $F(3,239)=2.08$ |
| Acculturation (0-44) | 16.41 (10.28) | $t(56)=0.37$ | $F(3,239)=15.02$*** |
| Attitudes MHS[1] (0-30) | 21.58 (5.53) | $t(241)=-0.08$ | $F(3,239)=3.80$* |
| Physical Health (0-5) | 3.22 (1.00) | $t(241)=0.96$ | $F(3,239)=0.17$ |
| Religious Coping (0-21) | 20.18 (3.52) | $t(241)=0.42$ | $F(3,239)=3.38$* |
| Resiliency (0-40) | 28.05 (6.98) | $t(241)=2.91$** | $F(3,239)=1.96$ |
| Social Support (0-30) | 18.29 (5.53) | $t(241)=1.45$ | $F(3,239)=0.17$ |

*Note*. *$p < .05$; **$p < .01$; ***$p < .001$; [1]MHS = Mental Health Services

### *Multivariate Analyses*

A logistic regression was run to predict use of professional health services for mental distress. Multivariate analyses showed that level of education, employment status and religious affiliation significantly predicted the model in Step 1 and remained significant after adding distress measures in Step 2. Anxiety significantly contributed to the model in Step 2 but did not in Step 3. However, level of education, employment status and religious affiliation remained significant after adding the interaction between distress scores and protective buffers in Step 3. The interactions did not significantly predict use of professional health services. See Table 3 for logistic regression results and Table 4 for formal resource utilization profiles.

**Table 3**. Logistic regression analysis predicting formal resource utilization ($N = 223$).

| Determinants | Step 1*** | | Step 2*** | | Step 3*** | |
|---|---|---|---|---|---|---|
| | *OR* | *CI*(95%) | *OR* | *CI*(95%) | *OR* | *CI*(95%) |
| *Predisposing Factors* | | | | | | |
| Gender [a] | 0.65 | (0.30, 1.38) | 0.67 | (0.31, 1.44) | 0.60 | (0.27, 1.31) |
| Age | 1.01 | (0.99, 1.03) | 1.01 | (0.99, 1.03) | 1.00 | (0.97, 1.02) |
| Education [b] | 3.89** | (1.43, 10.56) | 4.60** | (1.63, 13.02) | 4.26* | (1.41, 12.92) |
| Employment [c] | 0.42* | (0.18, 0.96) | 0.43* | (0.19, 0.98) | 0.42* | (0.18, 0.99) |
| Religion [c] | 3.29** | (1.56, 6.90) | 3.12** | (1.48, 6.59) | 3.12** | (1.43, 6.76) |
| *Enabling Factors* | | | | | | |
| Anxiety x Resiliency | | | 1.00 | (1.00, 1.01) | 1.00 | (0.99, 1.00) |
| Hwa-byung x Resiliency | | | 1.00 | (1.00, 1.00) | 1.00 | (1.00, 1.00) |
| *Need Factors* | | | | | | |
| Anxiety | | | | | 1.45* | (1.08, 1.95) |
| Hwa-byung | | | | | 0.99 | (0.81, 1.21) |
| Nagelkerke $R^2$ | 0.17 | | 0.18 | | 0.24 | |

*Note*. *$p < .05$; **$p < .00$; ***$p < .001$; Reference Categories: [a]Female, [b]High School or less, [b]Employed, [c]Other

**Table 4**. Formal resource utilization profiles.

| Factors | Used Professional Services | Did Not Use Professional Services |
|---|---|---|
| *Predisposing* | | |
| | Female | Male |
| | Younger | Older |
| | **More educated** | **Less educated** |
| | **Employed** | **Not employed** |
| | Seen MHS[1] | Did not see PHMS[1] |
| | **Non- SDA[2]** | **SDA[2]** |
| *Enabling* | | |
| | Lower levels of resiliency | Higher levels of resiliency |
| *Need* | | |
| | Higher levels of anxiety | Lower levels of anxiety |
| | Higher levels of hwa-byung | Lower levels of hwa-byung |

*Note*: Variables in bold significant at the multivariate level; [1]PHMS = Professional Mental Health Services, [2]SDA = Seventh-day Adventist

A multinomial logistic regression was run to predict informal resource utilization. The final model was statistically significant ($\chi^2$=95.06; $p < .001$). Results showed that gender, attitudes toward professional mental health services, acculturation, and views of God and religion influenced what type of resources that they were most likely to use. Specifically, respondents that did not use any informal health service resources were 15% less likely to view professional mental health services favorably than those that used both types of coping methods. In addition, those that only used solitary coping methods were 64% less likely to be female, 12% less likely to have positive view of God/religion and 5% less likely to be acculturated than those that used both types of coping methods. Respondents that reported that they talked to others as a personal coping method were 17% less likely to have positive view of God/religion than those that used both types of coping methods. Survey language, age, marital status, and generational status did not significantly contribute to the final model. See tables below for results and profiles.

**Table 5**. Logistic regression predicting informal resource utilization (final model including only significant variables at the 0.05 level) (*N*=236).

| Resource Type | | Estimate | *SE* | Wald | d f | Odds Ratio | CI(95%) |
|---|---|---|---|---|---|---|---|
| 1 | *Intercept* | 0.08 | 4.25 | 0.00 | 1 | | |
| None | PHMS | -0.16 | 0.80 | 3.97 | 1 | 0.85 | (0.73, 1.00) |
| 2 | *Intercept* | 4.52 | 1.69 | 7.17 | 1 | | |
| Solitary | Acculturation | -0.05 | 0.03 | 4.01 | 1 | 0.95 | (0.90, 1.00) |
| | Gender[a] | -1.02 | 0.37 | 7.66 | 1 | 0.36 | (0.18, 0.74) |
| | Religious Coping | -0.13 | 0.05 | 6.65 | 1 | 0.88 | (0.80, 0.97) |
| 3 | *Intercept* | 4.58 | 2.2 | 4.32 | 1 | | |
| Talking to Others | Religious Coping | -0.19 | 0.06 | 9.4 | 1 | 0.83 | (0.74, 0.93) |

Note. Model chi-square = 95.06; *p*<0.001, –2 log likelihood = 419.88, Pseudo $R^2$ (Nagelkerke) = 0.37; The reference category is: 4 (Both), [a]Female

**Table 6**. Informal resource utilization profiles.

| Factor | None | Solitary Coping | Talk to Others | Both |
|---|---|---|---|---|
| *Predisposing* | | | | |
| | Survey in Korean | Survey in Korean | Survey in English | Survey in English |
| | Male | **Male** | Female | Female |
| | Oldest Mean Age | Older Mean Age | Younger Mean Age | Youngest Mean Age |
| | Married | Married | Not Married | Not Married |
| | 1st Generation | 1st Generation | 2nd Generation | 2nd Generation |
| *Enabling* | | | | |
| | Least Acculturated | **Less Acculturated** | More Acculturated | Most Acculturated |
| | **Most Negative Views of MHS[1]** | Negative Views of MHS[1] | Positive Views of MHS[1] | Positive Views of MHS[1] |
| | Less Positive Religious Coping | **Less Positive Religious Coping** | **More Positive Religious Coping** | Most Positive Religious Coping |

*Note*: Variables in bold significant at multivariate level; Reference group "Both";
[1]MHS = Mental Health Services

## Discussion

The purpose of this study was to examine factors that influence the use of formal and informal resource utilization for mental distress among Korean-Americans using a multi-level conceptual model to analyze the various components that impact help-seeking behavior.

Overall, predisposing factors appeared to have the greatest impact on formal resource utilization. As seen in prior literature (Kim & Im, 2015; Saint Arnault, Woo, & Shibusawa, 2018) women were more likely to utilize resources both within and outside of the community to deal with mental distress in comparison to men who were more likely to not use any type of resources or used solitary based ones.

In contrast to Ryu, Young, & Park's study (2001), whether one had health insurance or not or access to regular care did not appear to significantly influence either

professional help-seeking behavior or what type of personal resources they utilized to cope with distress. Song et al. (2010) suggests that health insurance status was indicative or personal and structural barriers to care. First generation KAs are more likely to have significant language barriers and seek employment that does not require English language skills. However these types of jobs often do not offer adequate health care access if at all (Ryu, Young, & Park, 2001). This may be why respondents with higher levels of education and those that were employed were significantly more likely to seek professional services at both the bivariate and multi-variate level indicating that level of access to care may be influenced by job type and awareness about resources.

An unexpected result was that those that identified as Seventh-day Adventists (SDA) were less likely to seek professional services for mental distress than those that other religious affiliations. However, after a closer examination of the socio-demographic profile of the two groups, it appeared that other variables may be driving the relationship. Further analyses revealed that SDAs were more likely to be have taken the survey in Korean, be older, and less acculturated. The relationship between religious affiliation and professional help-seeking behavior appeared to be driven more so by the intersection of other factors rather than religious beliefs based on denomination.

Enabling factors such as views about professional mental health services (Kim & Im, 2015), positive views of God/religion (Lee et al., 2014), and higher levels of acculturation (Oh, Koeske, & Sales, 2002) can also increase the likelihood of using multiple types of resources, both formal and informal, to alleviate distress. While resiliency did not appear to act as protective buffer for anxiety, it appears that other enabling factors, such as view of professional mental health services, religiosity, and

acculturation may exert a greater influence, which can help inform the development of effective resources and treatment options.

While hwa-byung and anxiety were significantly correlated with whether respondents used formal resources or not at the bivariate level, these need factors did not significantly contribute to the model at the multivariate level. Frequency of hwa-byung, depression, or anxiety symptoms did not appear to influence what type of informal resources respondents used at either the bivariate or multivariate level. While it is critical to understand the scope of distress, the type of distress experienced may not necessarily inform the development of interventions or resources.

*Limitations*

This study focused only on recruiting at churches in the greater Los Angeles area and the information gleaned in this study can only be generalized to similar population groups. Due to the importance of networking in Korean culture, the researcher had limited success in finding participants in which she had no personal connections and heavily relied on convenience or snowball sampling. However, the recruited sample was a diverse group of community participants from varying educational and employment background, religious affiliation, generational status, age and gender. Also, it is important to note that outcomes were determined and analyses were conducted cross-sectionally, therefore a true cause-effect relationship cannot be established.

**Conclusion**

Results support the need for culturally appropriate informal mental health

resources that take into account various factors that influence help-seeking behavior at both the formal and informal level. With the low rate of professional service utilization, it is becoming increasingly critical that interventions that can be practiced privately or in a group (i.e. mindfulness), that have been proven to reduce mental distress among this population in a manner that is not stigmatizing and easily accessible (i.e. churches and community centers) be incorporated. It is suggested that future studies be conducted to further explore which types of interventions would be most effective in not only decreasing mental distress but also in identifying interventions or resources people are most likely to use based on their unique intersections of factors that include gender.

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**CHAPTER SEVEN**

**CONCLUSION**

The purpose of this dissertation was to explore the scope of hwa-byung, depression, and anxiety and to assess if there were differences in levels of distress in regard to language preference, genders, age, generational status, and church roles in addition to exploring potential protective factors for distress using Critical Race Theory as the theoretical framework. It also examined factors that influence the use of formal and informal resource utilization for mental distress among Korean Americans using a multi-level conceptual model (Anderson Healthcare Utilization Model) to analyze the various components that impact help-seeking behavior.

The rates of mental distress symptom occurrences for anxiety and depression were much higher (NIMH 2017; NIMH 2018) for Korean Americans in comparison to the general U.S. population. In addition, in contrast to prior studies on Hwa-byung (Min, Suh, & Song, 2009; Min et al., 2009; Lee et al., 2012), there were high rates of occurrences for HB symptoms regardless of gender, marital status, level of education, if they had health insurance, or regular access to care indicating that the scope of this cultural illness is evolving into more than a middle-aged women's disease and that greater attention needs to be made on the multiple factors that influence HB.

While generational status, marital status, income, and the language respondents took the survey in significantly predicted distress scores, the level of acculturation did not significantly influence distress scores. The acculturation scale used in this study had been shown to be reliable and valid among Korean Americans (Choi & Reed, 2011), indicating

that while this was still an appropriate scale to use in the study, a multi-level approach that reflects the fluid and diverse experiences of living outside of one's country of origin.

As observed in Leong & Lau (2001) and Cheung, Leung, & Cheung's studies (2011), the relationship between physical health, resiliency, views of God and religion, and mental health reflects the holistic view of the body in which the physical, spiritual, and mental are explicably interwoven. This provides support that health, resiliency, and religiosity can potentially act as protective buffers for distress in the KA community that is culturally sensitive to the needs of the community.

As seen in prior literature (Kim & Im, 2015; Saint Arnault, Woo, & Shibusawa, 2018) women were more likely to utilize resources both within and outside of the community to deal with mental distress in comparison to men who were more likely to not use any type of resources or used individually based ones. Enabling factors such as views about professional mental health services (Kim & Im, 2015), positive views of God/religion (Lee et al., 2014), and higher levels of acculturation (Oh, Koeske, & Sales, 2002) can also increase the likelihood of using multiple types of resources, both formal and informal, to alleviate distress. While resiliency did not appear to act as protective buffer for anxiety, it appears that other enabling factors, such as view of professional mental health services, religiosity, and acculturation may exert a greater influence, which can help inform the development of effective resources and treatment options.

The majority of the respondents had health insurance (87.8%) and access to regular health care (80.9%) yet there were still high levels of distress and only 18.1% stated that they had seen a professional services to deal with mental distress. While it is still critical to increase access to health insurance and services, personal and structural

barriers to care utilization should also be explored (Song et al., 2010) in addition to remaining diligent in increasing awareness about the effects of mental distress and advocating for culturally appropriate resources.

**Practice Implications**

This study has affirmed demonstrated an ideal starting place to build support and acceptance for mental health services are the Korean churches. A social phenomenon that was observed in Korean immigrants was the significant increase in church attendance or involvement. While some were Christians prior to immigrating, others did not necessarily have a religious affiliation. Studies show that Korean ethnic churches provide critical support and often are the networking system for Korean immigrants. Being involved in these churches not only provides fellowship with other Korean immigrants and ways to maintain Korean culture, it also a way for Korean immigrants to find social services. Church involvement can also improve social status and positions for adults (Min, 1992; Chai, 2001; Chong & Gul, 1991; Kim & Kim, 2001). Therefore, with the influence of churches and church leaders, it is suggested that there be an increased effort for mental health organizations and providers to collaborate with Korean churches, in particular those that provide the most protective buffers, to increase awareness and to disseminate information to help break down the stigma of mental illnesses and distrust of mental health service providers. Community centers located at or near churches that center on a holistic framework provide an array of cultural appropriate physical, mental, and spiritual services can help ease the stigma of mental illness and may provide encouragement for open dialogue and awareness about mental health and mental illness in the community. In

addition, funding or support for mental health training for pastors may also assist in encouraging people to utilize mental health services when faced with challenges, especially those that feel overwhelmed and appear to have exhausted all other sources for help.

## Alternative Policy Suggestions

While the Health Care Reform Act increases access to services, there is little consideration for culturally appropriate and relevant services. Policies that provide funding for community support, such as the CMHC Act, may help reduce barriers in accessing services. It is suggested that interventions use cultural capital that exists in the community by incorporating the three core cultural concepts. The concepts of *han* (collective suffering), *jeong* (social networking), and *noonchi* (social awareness), can be utilized through increasing awareness of mental health challenges and its prevalence to lessen the idea that mental illness is a personal problem that should be dealt with alone and in private. Understanding *han*, in particular, may help build the collaborative community support for facing mental health challenges. Although the root of *han* developed during the historically difficult times, Koreans today connect to this universal human experience through the hardships of their parents and ancestors or through their own marginalized experiences such as being discriminated against because of their race, ethnicity, or gender. Building an understanding that mental health challenges are also part of that universal suffering can help break down the stigma of seeking help or speaking about mental illnesses which can lead to using *jeong* to build the social support needed to disseminate information and resources. Developing this openness and acceptance may

transform the perceived individualistic and privately issue so that it does not violate

*noonchi* when bringing up mental health or mental illness.

Federal policies that fund programs that include components that educate,

encourage talking about mental health, and promoting mental well-being in the

curriculum (Cowen, Hightower, Pedro-Carroll, Work, Wyman, & Haffey, 1996; Durlak

& Wells, 1997; Weisz, Sandler, Durlak, & Anton, 2005) and supplementing early

screening efforts for depression and other mental health concerns starting in elementary

schools (Greenberg, Domitrovich, & Bumbarger, 1999; 2001) in both Korean and

English is needed to better address the mental health needs of Koreans in the United

States. It is also important to connect Korean parents with facilitators or service providers

who are familiar with the culture and can speak Korean to decrease cultural and language

barriers. While schools have school psychologists, social workers, and/or counselors,

these services tend to focus on treating students that are already showing signs of mental

illness or emotional distress (Richardson, Morrissette, & Zucker, 2012). When

normalizing and creating a safe space through preventative interventions to dialogue

about mental health and mental illness, it helps change the perception that the burden of

mental illness is an individualistic and shameful problem into a challenge that the looks

to the community and institutions for support and resources while also emphasizes the

importance of prevention and maintaining mental well-being.

## Future Studies

Modern Korean American women, in particular the first generation, are still

expected to be the main caretakers for both their children and their elderly parents even if

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they work (Chun et al., 2008). This expectation appeared to cause greater stress and pressure for women in roles where their husband's position was perceived to supersede their own, such as roles in church. Traditionally, men fulfill higher-level church leadership roles and women are rarely nominated/elected as elders or accepted as pastors (Choi-Kim, 2011). KA pastor's wives, in particular, are often expected to support their husband's work (2011). They must somehow balance heavy responsibilities and obligations to their family, the church, and to their work or career, often at the cost to their own well-being (Baek, Ortiz, & Alemi, n.d.; Hyun & Shin, 2010). With limited literature on Korean American women in roles where there is intense scrutiny and higher levels of expectations with minimal support from the community, it is critical that the scope and understanding of the unique mental health challenges of KA clergy wives be explored. This, dissertation originally proposed that mental distress experiences of KA pastor's wives be conducted to see if there were differences in scope and factors that impacted distress compared to the rest of the sample. To ensure that pastor's wives were represented in the sample, an additional 40 to 50 individuals were supposed to be recruited for the study. However, because of resource constraints, the researcher was unable to recruit the minimum number of pastor's wives that would have allowed the researchers to separately analyze the results specifically for this subgroup. In addition, to protect the identity of pastor's wives, they were merged with along with other participants that identified as church leaders. It is suggested that a future study, specifically looking at the experiences and distress of pastor's wives be conducted.

**Conclusion**

In conclusion, results from this study support the need for culturally appropriate informal mental health resources that take into account various factors that influence help-seeking behavior at both the formal and informal level. With the low rate of professional service utilization, it is becoming increasingly critical that interventions that can be practiced privately or in a group (i.e. mindfulness), that have been demonstrated to help reduce mental distress among this population in a manner that is not stigmatizing and easily accessible (i.e. churches and community centers) be incorporated. It is suggested that future studies be conducted to further explore which types of interventions would be most effective in not only decreasing mental distress but also in identifying interventions or resources people are most likely to use based on their unique intersections of factors that include gender, attitudes about professional services, level of acculturation, and religiosity.

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**INFORMED CONSENT DOCUMENT (ENGLISH VERSION)**

LOMA LINDA UNIVERSITY

School of Behavioral Health

**INFORMED CONSENT DOCUMENT**

# KOREAN AMERICAN MENTAL HEALTH STUDY

## PURPOSE

Hi, my name is Kelly Baek and I'm a doctoral student at Loma Linda University. The purpose of the study is to understand mental health experiences and help-seeking behavior amongst Koreans in the greater Los Angeles area. We will ask questions about things that can make it hard to get through the day as well as things that may stop you from asking for help or encourage you to ask for help. We believe that this study is important because there isn't enough information about mental health in the Korean community in the U.S. This study will help us understand what the concerns are, how serious the concerns are, and the best ways people can get help. You are invited to participate in this research study because you are of Korean ancestry and 18 years of age or older.

## PROCEDURES

If you are willing to take the survey, it can take up to 30 minutes to complete. The survey will take place at Korean churches in the Greater Los Angeles area or may be completed at a time and place that is convenient for you and returned to Kelly Baek. The survey is offered in both Korean and English and both versions are also available online through Qualtrics. The survey asks questions about your experiences with depression, anxiety, stress, and Hwa-byung, how you cope with distress, things that impact how you deal with challenges, and who you can go to for help. By taking the hard-copy or online survey, you will be giving your consent to participate in this study.

## RISKS

There are minimal risks if you take part in this study. Some of the questions may cause embarrassment, anxiety, and/or may be upsetting or make you

uncomfortable.  If you do not wish to answer a question, you can skip it and go to the next question.  If you do not wish to participate you can stop. A mental health resource list will be available for anyone who wants it.  There is also the possibility that confidentiality could be breached. In order to protect your identity the information you provide on the survey will be anonymous. This means that no identifying information such as your name will be collected. This will prevent identifying you by name in any publications describing the results of this study. Data from this study will be stored in a locked cabinet in a locked room in the Department of Social Work and Social Ecology at Loma Linda University. Information from surveys will be entered into a computer data file, will be password protected, and only members of the research team will have access to it.

## BENEFITS

Although you may not benefit directly from this study, what we learn from the study may help others in the future since this study will provide important information about mental distress in Koreans in the United States and what helps or stops them from getting help. It can also help us advocate for policy changes so Koreans can get the mental health support that they need.

## RIGHTS

Participation in this study is voluntary. This means that if at any time while completing the survey you find that you do not wish to take part you may refuse to continue. If you do not want to answer a certain question you may decline. Your decision of whether or not to take part in this study or end the interview will not affect your present or future relationship with me, or any related organization.

## ADDITIONAL COSTS/REIMBURSEMENTS

There will be no cost to you for taking part in this study. As a sign of appreciation for your participation a $5 donation will be made on your behalf to the church of your choice.

## IMPARTIAL 3rd PARTY CONTACT

If you want to contact an impartial third party not part of this study about any questions or complaints you may have about this study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, patientrelations@llu.edu for information and assistance.

## INFORMED CONSENT STATEMENT

If your questions about this research study have been answered, and you do not have any more questions after Kelly Baek's explanation of the consent form – you can simply provide a verbal response to her regarding your agreement to complete the survey. But please understand that by agreeing to take part in this research study, you are not waiving your rights. Also, your willingness to take part in this study does not release Kelly Baek or Larry Ortiz, their institution or sponsors from their responsibilities. You may contact Dr. Larry Ortiz, the principle investigator, at (909) 379-7585 or larryortiz@llu.edu during routine office hours.

You may also contact Kelly Baek at (248) 720-8641 or at [kbaek@llu.edu](mailto:kbaek@llu.edu) if you have additional questions or concerns. You may keep this consent form for your records, which has been signed by Kelly Baek.

## INVESTIGATOR'S ATTESTATION

I have reviewed the contents of this consent form with the person providing verbal consent. I have explained potential risks and benefits of the study. A signed copy of the consent form has been provided to the participant, and I have also kept a copy for myself, which includes a unique code confirming that consent was obtained – written at the top of the first page.


_____                          _____

Signature of Investigator                          Date

Kelly Baek, MSW

**QUESTIONNAIRE (ENGLISH VERSION)**



**Korean American Mental Health Study**

Student Investigator:
Kelly Baek, MSW

Loma Linda University

Survey Number _____

**DONATION**

What church would you like the $5 donation to go to?
_____

**DEMOGRAPHICS**

*We are interested in learning a little about you. Please circle the answer that applies to you or fill in the blank to the best of your ability.*

1. Gender:    *a. Female*        *b. Male*

2. Age:_____

3. Marital Status:
    *a.  Never Married        b. Married     c. Widowed     d. Divorced/Separated*

4. Level of Education:
    *a.  High School or less     b. Some College/Associate/Technical Training
         c. Bachelor's Degree*

    *d. Master's Degree or Higher*

5. Employed:       *Yes (includes self-employed)*               *No*

6. Current Occupation:_____

7. Able to comfortably pay monthly bills:  *Yes*               *No*

8. Place of Birth:          *a. USA*          *b. Korea*          *c. Other* (please specify)_____

     *a.*  If born in another country, what year did you move? _____

9. Do you currently have health insurance?          *Yes*               *No*

     *a.*  If yes, please list all your insurance providers:
     _____

10. Do you have regular access to a health care provider?  *Yes*               *No*

11. In the past year, have you visited a mental health specialist?  *Yes*               *No*

12. Current Role in Church:
     *a.*  **Pastor**
     *b.*  **Pastor's Wife**
     *c.*  **Elder**
     *d.*  **Deacon/Deaconess**
     *e.*  **Member**
     *f.*  **Other**_____

13. Religious Affiliation
     *g.*  **Baptist**
     *h.*  **Catholic**
     *i.*  **Methodist**
     *j.*  **Presbyterian**
     *k.*  **Seventh-day Adventist**
     *l.*  **Other** _____

## SOCIAL SUPPORT

*We want to understand your measure of social engagement. Please circle that answer that best fits.*

**FAMILY: Considering the people to whom you are related by birth, marriage, adoption, etc.…**

1. How many relatives do you see or hear from at least once a month?

*0 = none     1 = one          2 = two          3 = three or four          4 = five thru eight*
     *5 = nine or more*

2. How many relatives do you feel at ease with that you can talk about private matters?

*0 = none    1 = one          2 = two          3 = three or four          4 = five thru eight*
*5 = nine or more*

3.  How many relatives do you feel close to such that you could call on them for help?

*0 = none    1 = one          2 = two          3 = three or four          4 = five thru eight*
*5 = nine or more*

**FRIENDSHIPS: Consider all of your friends including those who live in your neighborhood**

4.  How many friends do you see or hear from at least once a month?

*0 = none    1 = one          2 = two          3 = three or four          4 = five thru eight*
*5 = nine or more*

5.  How many friends do you feel at ease with that you can talk about private matters?

*0 = none    1 = one          2 = two          3 = three or four          4 = five thru eight*
*5 = nine or more*

6.  How many friends do you feel close to such that you could call on them for help?

*0 = none    1 = one          2 = two          3 = three or four          4 = five thru eight*
*5 = nine or more*

## COPING

*Think about how you try to understand and deal with major problems in your life. To what extent is each involved in the way you cope? Please answer the following questions by circling your answer.*

1.  I think about how my life is part of a larger spiritual force.

*a great deal          quite a bit                somewhat                not at all*

2.  I work together with God as partners to get through hard times.

*a great deal          quite a bit                somewhat                not at all*

3.  I look to God for strength, support, and guidance in crises.

*a great deal          quite a bit                somewhat                not at all*

4.  I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.

*a great deal          quite a bit                somewhat                not at all*

5. I wonder whether God has abandoned me.

*a great deal*        *quite a bit*        *somewhat*        *not at all*

6. I try to make sense of the situation and decide what to do without relying on God.

*a great deal*        *quite a bit*        *somewhat*        *not at all*

7. To what extent is your religion involved in understanding or dealing with stressful situations in any way?
*very involved*        *somewhat involved*        *not very involved*
        *not involved at all*


***Think about how you coped with mental distress in the <u>PAST YEAR</u>. Please answer the following questions by circling all answers that apply.***

1. Who have you gone to for professional help to cope with mental distress (i.e. depression, stress, anxiety) in the **past 12 months**?
    *a.* Primary Care Physician
    *b.* Psychiatrist
    *c.* Psychologist
    *d.* Marriage Family Therapist
    *e.* Social Worker
    *f.* Other_____
    *g.* None of the above/Did not go

2. How have you personally coped with mental distress in the **past 12 months**?
    *a.* Dealt with it by myself
    *b.* Prayed
    *c.* Talked to my pastor/ spiritual leader
    *d.* Talked to family and friends
    *e.* Used traditional healing (i.e. herbal medicine/treatments)
    *f.* Ignored it
    *g.* Exercised
    *h.* Other_____


**EXPERIENCES WITH DISTRESS**

***Please indicate to what extent you agree or disagree with the following statements below by circling your answer.***

1. My life seems unhappy.

*strongly disagree*        *slightly disagree*        *slightly agree*        *strongly agree*

2. I am sometimes remorseful.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

3.  I regret how I spent my life.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

4.  I feel sad and resentful about how my life turned out.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

5.  I have feelings of unfairness.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

6.  It is difficult to control my thoughts/mind because I am a nervous wreck.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

7.  My nervousness extends to physically shaking my hands and body, so I can't do anything.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

8.  I am frequently disappointed in myself.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

9.  My face is frequently flushed and I feel feverish.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

10. I often feel a burning sensation in my chest.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

11. I often feel something rising up my chest when I get angry.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

12. When I get angry, my hands feel numb or shake.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

13. I have difficulty digesting foods and frequently have an upset stomach.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

14. In general, I am very tired.

*strongly disagree*     *slightly disagree*     *slightly agree*     *strongly agree*

15. I think life is unfair and things are unjust.

*strongly disagree*        *slightly disagree*        *slightly agree*        *strongly agree*

**Please indicate to what extent you agree or disagree with the following statements below by circling your answer.**

1. I feel suddenly scared for no reason.

*not at all*        *a little*        *quite a lot*        *extremely*

2. I feel fearful.

*not at all*        *a little*        *quite a lot*        *extremely*

3. I feel faint, dizzy, or weak.

*not at all*        *a little*        *quite a lot*        *extremely*

4. I feel tense or keyed up.

*not at all*        *a little*        *quite a lot*        *extremely*

5. I blame myself for things.

*not at all*        *a little*        *quite a lot*        *extremely*

6. I have difficulty falling asleep and/or staying asleep.

*not at all*        *a little*        *quite a lot*        *extremely*

7. I feel hopeless about the future.

*not at all*        *a little*        *quite a lot*        *extremely*

8. I feel blue.

*not at all*        *a little*        *quite a lot*        *extremely*

9. I feel everything is an effort.

*not at all*        *a little*        *quite a lot*        *extremely*

10. I have feelings of worthlessness.

*not at all*        *a little*        *quite a lot*        *extremely*

*Please answer the following questions about your perceived stress below by circling your answer.*

1.  **In the last month**, how often have you been upset because of something that happened unexpectedly?

    *never                  almost never              sometimes              fairly often*

2.  **In the last month**, how often have you felt that you were unable to control the important things in your life?

    *never                  almost never              sometimes              fairly often*

3.  **In the last month**, how often have you felt nervous and "stressed"?

    *never                  almost never              sometimes              fairly often*

4.  **In the last month**, how often have you felt confident about your ability to handle personal problems?

    *never                  almost never              sometimes              fairly often*

5.  **In the last month**, how often have you felt that things were going your way?

    *never                  almost never              sometimes              fairly often*

6.  **In the last month**, how often have you found that you could not cope with all the thing that you had to do?

    *never                  almost never              sometimes              fairly often*

7.  **In the last month**, how often have you been able to control the irritations in your life?

    *never                  almost never              sometimes              fairly often*

8.  **In the last month**, how often have you felt that you were on top of things?

    *never                  almost never              sometimes              fairly often*

9.  **In the last month**, how often have you been angered because of things that were outside of your control?

    *never                  almost never              sometimes              fairly often*

10. **In the last month**, how often have you felt difficulties were piling up so high that you could not overcome them?

    *never                  almost never              sometimes              fairly often*

**FEELINGS ABOUT MENTAL HEALTH SERVICES**

*Please answer the following questions about your feeling about professional mental services below by circling your answer.*

1. If I believed that I was having a breakdown, my first inclination would be to get professional attention.

   *disagree*          *partly disagree*          *partly agree*          *agree*

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

   *disagree*          *partly disagree*          *partly agree*          *agree*

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

   *disagree*          *partly disagree*          *partly agree*          *agree*

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

   *disagree*          *partly disagree*          *partly agree*          *agree*

5. I would want to get psychological help if I were worried or upset for a long period of time.

   *disagree*          *partly disagree*          *partly agree*          *agree*

6. I might want to have psychological counseling in the future.

   *disagree*          *partly disagree*          *partly agree*          *agree*

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

   *disagree*          *partly disagree*          *partly agree*          *agree*

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

   *disagree*          *partly disagree*          *partly agree*          *agree*

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

   *disagree*          *partly disagree*          *partly agree*          *agree*

10. Personal and emotional troubles, like many things, tend to work out by themselves.

*disagree*          *partly disagree*          *partly agree*          *agree*

## ACCULTURATION

*Please answer the following questions below by circling your answer. Please note that K = Korean, E = English and NK = Non Korean.*

1. In general, what language(s) do you read and speak?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

2. What was the language(s) you used as a child?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

3. What language(s) do you usually speak at home?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

4. In which language(s) do you usually speak with friends?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

5. In what language(s) are the T.V. programs you usually watch?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

6. In what language(s) are the radio programs you usually listen to?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

7. In general, in what language(s) are the movies, T.V. and radio programs you *prefer* to watch and listen to?

   *all K*          *more K than E*          *half & half*          *more E than K*          *all E*

8. Your close friends are:

   *all K*          *more K than NK*          *half & half*          *more NK than K*          *all NK*

9. You prefer going to social gatherings/parties at which the people are:

   *all K*          *more K than NK*          *half & half*          *more NK than K*          *all NK*

10. The persons you visit or visit you are:

*all K          more K than NK          half & half          more NK than K          all NK*

11. If you could choose your children's friends, you would want them to be:

*all K          more K than NK          half & half          more NK than K          all NK*

**HEALTH STATUS**

***Please answer the following questions about your health status below by circling your answer.***

1. In general, would you say your health is:

   *excellent          very good          good          fair          poor
   very poor*

2. How much does your health now limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

   *limited a lot          limited a little          not limited at all*

3. How much does your health now limit you in in climbing several flights of stairs?

   *limited a lot          limited a little          not limited at all*

4. During the **past 4 weeks**, have you accomplished less than you would have liked at work or with other regular daily activities as a result of your physical health? *Yes          No*

5. During the **past 4 weeks**, were you limited in the kind of work or other activities as a result of your physical health?          *Yes          No*

6. During the **past 4 weeks**, did you accomplish less than you would have liked with your work or other regular daily activities as a result of emotional problems (such as feeling depressed or anxious)?     *Yes          No*

7. During the **past 4 weeks**, did you do your work or daily regular activities less carefully than usual as a result of emotional problems?     *Yes          No*

8. During the **past 4 weeks**, how much did pain interfere with your normal work (including work outside of the home and housework)?

   *not at all          a little bit          moderately          quite a bit          extremely*

9. How much of the time during the **past 4 weeks** have you felt calm and peaceful?

   *all          most          a good some          a little          none*

10. How much of the time during the **past 4 weeks** did you have a lot of energy?

    *all          most          a good some          a little          none*

11. How much of the time during the **past 4 weeks** have you felt down-hearted and blue?

*all          most                a good some      a little              none*

12. During the **past 4 weeks**, how much of the time has your physical and emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

*all          most                a good some      a little              none*


**RESILIENCY**

*Please answer the following questions about your perceived resiliency below by circling your answer.*

1. I am able to adapt to change.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

2. I can deal with whatever comes my way.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*


3. I try to see the humorous side of things when I am faced with problems.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

4. Having to cope with stress can make me stronger.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

5. I tend to bounce back after illness, injury, or other hardships.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

6. I believe that I can achieve my goals, even if there are obstacles.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

7. Under pressure, I stay focused and think clearly.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

8. I am not easily discouraged by failure.

*not true at all   rarely true      sometimes true          often true       true nearly all the time*

9.  I think of myself as a strong person when dealing with life's challenges and difficulties.

*not true at all    rarely true        sometimes true            often true        true nearly all the time*

10.  I am able to handle unpleasant or painful feelings like sadness, fear, or anger.

*not true at all    rarely true        sometimes true            often true        true nearly all the time*

**INFORMED CONSENT DOCUMENT (KOREAN VERSION)**

LOMA LINDA UNIVERSITY

School of Behavioral Health
(로마린다 대학교 행동건강학과)

사전 동의서

# 미주 한인 정신보건 연구

## 목적

안녕하십니까? 저는 현재 로마린다 대학교에서 박사 과정중에 있는 켈리 백(Kelly Baek) 이라고 합니다.  본 질문지의 목적은 로스엔젤레스 지역에 거주하는 한인분들의 경험적 정신 건강과 한인들 간의 서로 돕는 경향의 상호관계를 이해하고자 하는 바에 있습니다. 본 질문지에는 귀하가 일상에서 겪는 어려움들과, 또는 그에 따른 도움이 필요할 때, 도움 요청 여부 결정에 영향을 주는 요소들과 관련된 문항들을 담고 있습니다.  현재 미주 한인을 대상으로 한 정신보건 관련 정보는 극미한 수준이며, 저희 연구진은 이 조사가 한인 사회의 정신보건적 사안들과 그 심각성을 이해하고, 사람들을 돕는데 최적의 방안을 찾는 데 중요한 자료가 될 거라고 믿습니다.  귀하는 본 연구의 대상인 18세 이상의 미주 한인으로써 설문 대상으로 초대되었습니다.

## 절차

본 조사는 설문 방식이며 최대 30분 가량 소요될수 있습니다.  장소는 로스엔젤레스 각 지역의 한인교회에서 진행되며, 연구자의 질문지 회수 방법과 참여자의 편의에 따라 시간과 장소를 변경할 수 있습니다.  본 질문지는 한국어와 영어로 제공되며, 온라인 상에서 Qualtrics를 통하여 작성될 수도 있습니다.  설문 내용은 우울증, 불안감, 스트레스, 화병 등을 동반한 경험과, 그에 따른 해소 방식, 그리고 어려움에 직면했을시의 대처 방식과 누구에게 도움을 청하는가 하는 등의 문항들을 담고 있습니다.  본 설문의 작성을 통해 귀하는 본 연구 참여에 동의하게 됩니다.

## 주의사항

본 설문 참여에 경미한 위험 요소가 있습니다.  설문의 답변 과정에서 몇몇 내용들은 당혹스럼, 불안감 등의 혼란스럽거나 불편한 감정 등을 느끼실수도 있습니다.  특정 질문에 답변을 원치 않으시면 답변하지 않고 다음 문항으로 넘기셔도 좋으며, 진행을 원치 않으실 경우 그만 두실수 있습니다.  정신보건 자료 목록은 누구에게나 열려 있으며, 기밀성이 깨질 가능성 또한 존재합니다. 참여 대상의 신원을 보호하기 위하여 모든 작성 정보는 익명으로 수집됩니다. 즉, 이름 등의 개인정보는 수집되지 않으며, 따라서 본 연구의 결과를 기술하는 모든 출판물에서의 개인 신원은 식별되지 않습니다.  본 설문 자료는 로마린다 대학의 사회복지 및 사회 생태학과 부서의 기록으로 잠겨서 보관되고, 수집된 정보들은 전산 기록으로 암호화되어 처리되며, 본 연구 팀 구성원만이 조회할수 있게 됩니다.

## 이익

이 연구를 통한 직접적인 혜택을 기대하긴 어려우나, 본 연구를 통해 얻는 자료는 미주 한인들의 정신보건에 대한 중요한 정보를 제공하며, 정신적 어려움과 관련한 도움을 받기에 어떠한 방해 요소들이 존재하는지 규명하는데 유용한 자료가 될 것입니다.  또한 필요에 따라, 한인분들을 대상으로 하는 정신보건과 연관된 정책적 변경과 지원을 위한 근거 자료로도 쓰일 수 있습니다.

## 권리

이 연구에 참여하는 것은 자발적입니다. 즉, 설문 작성 도중 진행 중단을 원하실 경우 언제든지 그만 두실 수 있으며, 특정 질문에 답변하기 원치 않으실 경우 건너 뛰셔도 됩니다.  귀하의 참여 여부 결정이 저와 관련된 기관이나 제 개인과의 관계에 영향을 미치지 않을 것입니다.

## 추가 비용/보상

이 연구에 참여하는데 드는 비용은 없으며 참여에 대한 감사의 표시로 귀하가 선택한 교회로 기부금 5달러가 전달됩니다.

## 중립적 제 3자 연락처

만약 이 연구에 대한 질문이나 불만 사항에 대하여 본 연구와는 무관한 중립의 제3자에게 연락하시길 원할 경우 다음의 연락처를 참조하십시오.
주소: Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354
전화: (909) 558-4647, 이메일: patientrelations@llu.edu

## 사전동의 진술문

본 연구에 대해서 이해하였고 켈리 백(Kelly baek)의 본 동의서 설명에 관한 추가적인 질문이 없으시다면, 본 설문 참여에 동의함을 구두로 응답하여 주시면 됩니다.  본 조사 참여에 동의함으로써 귀하의 권리를 포기하는 것이 아님을 이해하십시오. 귀하의 참여 의사가 캘리 백과 Dr. Larry Ortiz 및 그들과 관련된 기관의 책임을 면제시키지 않습니다.

만약 추가적인 질문이나 궁금한 점이 있으시면 정상 업무 시간에 아래로 연락
주시기 바랍니다.
수석 연구원Dr. Larry Ortiz, 전화: (909) 379-7585 이메일:
larryortiz@llu.edu.
연구원 켈리 백(Kelly Baek), 전화: (248) 720-8641 이메일: kbaek@llu.edu.
귀하는 켈리 백의 서명이 포함된 본 동의서를 기록물로 보관하실수 있습니다.

**연구자의 증명**
저는 본 동의서의 내용을 구두 동의한 사람과 함께 검토하였으며, 이 연구를 통한
잠재적 위험성과 이점에 대하여 설명하였습니다. 서명된 동의서 사본은 각
참여자와 본인에게 전달되었으며, 각 문서 첫 페이지 상단에는 이를 확인하는
고유 부호를 담고 있습니다.


_____          _____
연구자 서명                    날짜
켈리 백(Kelly Baek), MSW

LOMA LINDA UNIVERSITY

School of Behavioral Health

## 미주 한인 정신보건 연구

조사 연구생:

켈리 백 (Kelly Baek), MSW

로마린다 대학교

설문 번호 _____

**기부**

기부금 5달러를 전하길 원하시는 교회를 적어 주세요

_____

**인구 통계적 정보**

*진행에 앞서 귀하의 일부 통계적 정보를 얻고자 합니다. 귀하에게 해당하는 답변에 동그라미를 치거나 빈 칸에 답변을 적어주시기 바랍니다.*

13. 성별:     *a.* 여     *b.* 남

14. 나이:_____

15. 결혼 여부:
    *a.* 미혼     *b.* 기혼     *c.* 사별     *d.* 이혼,별거

16. 최종 학력:
    *a.* 고등학교 졸업 또는 이하     *b.* 일부 대학, 전문대학, 기술 교육

    *c.* 학사     *d.* 석사 학위 이상

17. 취업여부:　　　　*예(자영업 포함)*　　　　　　　*아니오*

18. 현재 직업: _____

19. 매 달 청구 금액을 부담 없이 지불하고 계십니까?:　　　　　*예*　　　　*아니오*

20. 출생지:　　　　*a.미국*　　　*b. 한국*　　　*c. 기타* _____

　　　　미국 외에서 태어나신 경우, 몇 년도에 이주하셨나요? _____

21. 현재 건강보험이 있으십니까?　　　　*예*　　　　*아니오*

　　　　있다면 해당 보험회사들을 적어주세요:
　　　　_____

22. 귀하는 정기적인 의료 혜택을 제공받고 계십니까?　　　　*예*
　　*아니오*

23. 지난 해에, 정신 건강 전문의를 방문한 적이 있으십니까?　　　　*예*
　　*아니오*

24. 현재 교회 내 직책:
　　　*a.* *목사*
　　　*b.* *목사 부인*
　　　*c.* *장로*
　　　*d.* *집사*
　　　*e.* *평신도*
　　　*f.* *기타*_____

14. 소속 교회:
　　　*g.* *침례교*
　　　*h.* *천주교*
　　　*i.* *감리교*
　　　*j.* *장로교*
　　　*k.* *제칠일 안식일 예수재림교*
　　　*l.* *기타* _____

## 사회 지원 정보
*귀하의 사교적 참여 규모를 알고자 합니다. 해당하는 답변에 동그라미를 쳐 주시기*
*바랍니다.*

**친인척 관계: 직계 , 결혼, 또는 입양을 통한 관계 등.**

7. 적어도 한달에 한번 이상 보거나 소식을 주고받는 친인척이 몇 명이신가요?

*없음*　　　*1명*　　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*

8. 사적인 주제로 편히 이야기 할수있는 친인척이 몇 명이신가요?

*없음*　　　　*1명*　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*

9. 도움을 청할수 있을 정도로 가깝다고 느끼는 친인척이 몇 명이신가요?

*없음*　　　　*1명*　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*


## 친구 관계: 주변 이웃을 포함한 모든 친구

10. 적어도 한달에 한번 이상 보거나 소식을 주고받는 친구가 몇 명이신가요?

*없음*　　　　*1명*　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*

11. 사적인 주제로 편히 이야기 할수있는 친구가 몇 명이신가요?

*없음*　　　　*1명*　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*

12. 도움을 청할수 있을 정도로 가깝다고 느끼는 친구가 몇 명이신가요?

*없음*　　　　*1명*　　　　*2명*　　　　*3~4명*　　　　*5~8명*　　　　*9명 이상*


## 대처 방식

*삶의 주요 어려움에 직면했을 때 어떻게 이해하고 대처해 나가는지 생각해 보십시오. 귀하의 대처 방식이 각 문항에 어느 정도까지 적용되는지 해당 답변에 동그라미를 쳐 주시기 바랍니다.*

8. 나의 삶은 더 큰 영적인 힘의 일부라고 생각해 본다.

*많이 그렇다*　　　　　　*상당히 그렇다*　　　*약간 그렇다*　　　*전혀 아니다*

9. 나는 어려움을 극복하기 위하여 내 동반자로써 하나님과 함께 대처해 나간다.

*많이 그렇다*　　　　　　*상당히 그렇다*　　　*약간 그렇다*　　　*전혀 아니다*

10. 나는 위기에 직면했을 때, 하나님께 힘과 지원과 인도를 간구한다.

*많이 그렇다*　　　　　　*상당히 그렇다*　　　*약간 그렇다*　　　*전혀 아니다*

11. 내가 마주하는 어려운 상황들은, 하나님이 내 죄와 나의 부족한 영성을 처벌하는 방식이라 여긴다.

*많이 그렇다*　　　　　　*상당히 그렇다*　　　*약간 그렇다*　　　*전혀 아니다*

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12. 나는 신에게 버려진게 아닐까 하는 의문이 든다.

**많이 그렇다**　　　　　　**상당히 그렇다**　　　　**약간 그렇다**　　　　**전혀 아니다**

13. 나는 직면한 상황을 이해하려 하며 하나님께 의지하지 않고 무엇을 해야 할지 결정하려고 한다.

**많이 그렇다**　　　　　　**상당히 그렇다**　　　　**약간 그렇다**　　　　**전혀 아니다**

14. 귀하의 종교는 귀하의 스트레스와 어려움을 이해하거나 돕는 데 얼마나 관여하고 있나요?

**크게 관여**　　　　**어느정도 관여**　　　　**약간 관여**　　　　　**전혀 관여되지 않음**

*지난 한해 동안 정신적 고통(Mental distress)에 어떻게 대처했는지 생각해 보십시오.*
*질문에 해당되는 모든 답변에 동그라미를 쳐 주시기 바랍니다.*

3. 지난 12개월 동안 정신적 고통(예: 우울증, 스트레스, 불안감 등)에 대처하기 위해서 전문적인 도움을 요청한 대상은 누구입니까?
   *a.* 주치의
   *b.* 정신의학 전문의
   *c.* 심리학자
   *d.* 결혼 가족상담 치료사
   *e.* 사회복지사
   *f.* 기타 _____
   *g.* 없음/찾지 않음

4. 지난 12개월 동안 겪은 정신적 고통에 개인적으로 어떻게 대처 하셨나요?
   *a.* 스스로 대처
   *b.* 기도
   *c.* 목사님 혹은 영적 지도자와의 대화
   *d.* 가족이나 친구들과의 대화
   *e.* 고전요법 (예: 한의학, 전통요법 등)
   *f.* 대처하지 않고 무시
   *g.* 운동
   *h.* 기타 _____

## 정신적 고통이 수반된 경험
*다음 진술에 어느정도 동의 혹은 부정하는지 해당 답변에 동그라미를 쳐 주시기 바랍니다.*

16. 나의 삶이 불행하다고 느낀다.

**강한 부정**　　　　**소극 부정**　　　　**소극 동의**　　　　**강한 동의**

17. 나는 종종 회한/죄책감에 가득 차 있다.

**강한 부정**　　　　**소극 부정**　　　　**소극 동의**　　　　**강한 동의**

18. 나는 어떻게 살아 왔는가에 대한 후회가 크다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

19. 내 삶이 진행된 결과에 슬프고 원망스러운 감정을 느낀다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

20. 불공정하다는 느낌을 자주 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

21. 신경 쇠약으로 인해 내 감정과 생각을 통제하기 어렵다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

22. 정서적 불안과 긴장감이 손 떨림 등의 증상으로 이어져 행동에도 제약을 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

23. 종종 내 자신에게 실망하곤 한다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

24. 얼굴이 자주 붉어지고 열이 나는 듯한 느낌을 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

25. 가슴이 타는듯한 느낌을 자주 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

26. 화가 날때 무언가 가슴쪽에서 올라오는 듯한 느낌을 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

27. 화가 날때 손이 마비되거나 떨리는 느낌을 받는다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

28. 음식을 소화하는데 어려움이 있으며 자주 배탈이 난다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

29. 일반적으로 나는 매우 피로하다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

30. 인생은 불공평하며 세상은 부당하다고 생각한다.

|  *강한 부정* | *소극 부정* | *소극 동의* | *강한 동의* |

다음 진술에 어느정도 동의 혹은 부정하는지 해당 답변에 동그라미를 쳐 주시기 바랍니다.

11. 갑자기 이유 없이 겁이 난다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*

12. 두려운 감정을 느낀다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*

13. 어지럽거나 약해진 느낌이 든다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*

14. 불안감 또는 긴장감을 느낀다.

*전혀 아니다*         *약간 그렇다*  *어느정도 그렇다*        *심하게 그렇다*

15. 나는 자책하는 경향이 있다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*


16. 잠들거나 숙면을 취하는데 어려움을 느낀다.

*전혀 아니다*         *약간 그렇다*  *어느정도 그렇다*        *심하게 그렇다*

17. 미래에 대한 희망이 없다.

*전혀 아니다*         *약간 그렇다*  *어느정도 그렇다*        *심하게 그렇다*

18. 나는 울적한 기분을 느낀다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*

19. 나는 모든것이 벅찬 듯한 느낌이 든다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*

20. 무가치하다는 감정이 든다.

*전혀 아니다*         *약간 그렇다*    *어느정도 그렇다*        *심하게 그렇다*


*귀하께서 인지하는 스트레스에 대하여 다음 질문들에 답변해 주시기 바랍니다.*

11. **지난 한 달 동안**, 예기치 않은 상황으로 인해 얼마나 자주 화가 나셨나요?

      *전혀 없음*          *거의 없음*          *가끔*          *꽤 자주*

12. **지난 한 달 동안**, 자신의 삶에 중요한 것들을 컨트롤 할 수 없다고 느낀 적이 얼마나 자주 있었나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

13. **지난 한 달 동안**, 귀하는 얼마나 자주 긴장되고 스트레스를 받으셨나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

14. **지난 한 달 동안**, 개인적인 문제를 해결하는 능력에 대한 자신감을 얼마나 자주 느끼셨나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

15. **지난 한 달 동안**, 모든 일이 자신의 뜻대로 흐르고 있다는 느낌을 얼마나 자주 느끼셨나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

16. **지난 한 달 동안**, 해야할 일들이 감당하기에 벅차다고 느껴진 적이 얼마나 자주 있었나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

17. **지난 한 달 동안**, 짜증을 유발하는 일들을 얼마나 자주 통제할수 있었나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

18. **지난 한 달 동안**, 자신이 모든 일들에 앞서 있다라고 느껴진 적이 얼마나 자주 있었나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

19. **지난 한 달 동안**, 귀하의 통제 밖의 일들로 인하여 얼마나 자주 화가 나셨나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

20. **지난 한 달 동안**, 극복하기 어려울 정도로 어려운 일이 쌓인다는 느낌을 얼마나 받으셨나요?

      *전혀 없음*           *거의 없음*          *가끔*          *꽤 자주*

# 정신건강 서비스에 대한 인식

정신건강 관련 전문 혜택에 대하여 귀하께서 어떻게 인지하는지 답변하여 주시기
바랍니다.

11. 내게 심리적인 문제점이 있다고 생각된다면, 나는 전문적인 도움을 받는 것을
첫째로 떠올릴 것이다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

12. 감정적 문제를 해결하기 위해서 심리학자와 상담한다는 생각은 그다지 좋은
방법이라 여기지 않는다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

13. 만약 이순간 내가 심각한 감정적 문제를 겪는다면, 심리적 치료를 통해 안정을
찾을수 있을거라고 본다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

14. 전문적인 도움 없이 내적 갈등과 두려움을 극복하려는 태도는 칭찬할만한 일이다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

15. 만약 내가 겪는 심리적 문제점이 장기간 지속될 경우 심리적인 도움을 요청할
의향이 있다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

16. 나는 미래에 심리 상담을 받기를 원할수도 있다.

   **동의하지 않음**　　　　　**소극적 비동의**　　　　　**소극적 동의**
   　**동의**

17. 감정적 문제를 혼자서 스스로 해결하기는 어려우며, 전문적인 도움을 통하여
해결할수 있다.

      *동의하지 않음*        *소극적 비동의*        *소극적 동의*
        *동의*

18. 심리 치료에 소비되는 비용과 시간을 생각하면, 내 개인에게 그만한 가치가 있는지는 의문이다.

      *동의하지 않음*        *소극적 비동의*        *소극적 동의*
        *동의*

19. 본인 문제는 스스로 해결해야 한다고 보며, 심리 상담은 최후의 수단이 되어야 할 것이다.

      *동의하지 않음*        *소극적 비동의*        *소극적 동의*
        *동의*

20. 개인적, 정서적 문제들은, 많은 것들과 마찬가지로 스스로 알아서 해결되는 경향이 있다.

      *동의하지 않음*        *소극적 비동의*        *소극적 동의*
        *동의*

## 문화 접변 (Acculturation)

*해당하는 답변에 동그라미를 쳐 주시기 바랍니다.*

12. 전반적으로 어느 언어를 주로 사용하고 계십니까?

*a. 전부 한국어*     *b. 한국어 위주*   *c. 한국어/영어 반반*   *d. 영어 위주*
    *e. 전부 영어*

13. 어릴 때 주로 어느 언어를 사용하셨나요?

*a. 전부 한국어*     *b. 한국어 위주*   *c. 한국어/영어 반반*   *d. 영어 위주*
    *e. 전부 영어*

14. 집에서 어느 언어를 주로 사용하십니까?

*a. 전부 한국어*     *b. 한국어 위주*   *c. 한국어/영어 반반*   *d. 영어 위주*
    *e. 전부 영어*

15. 친구들과 소통할때 주로 어느 언어를 사용하십니까?

*a. 전부 한국어*     *b. 한국어 위주*   *c. 한국어/영어 반반*   *d. 영어 위주*
    *e. 전부 영어*

16. 주로 어느 언어의 텔레비젼 프로그램을 시청하십니까?

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

17. 주로 어느 언어의 라디오 프로그램을 청취하십니까?

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

18. 영화,텔레비젼,라디오 등을 접할 때 주로 어느 언어를 선호하십니까?

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

19. 나의 가까운 친구들은 주로:

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

20. 내가 선호하는 사회적 모임/파티 등에는 주로:

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

21. 내가 방문하거나 나를 방문하는 사람들은 주로:

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

22. 만약 내 자녀의 친구들을 택할수 있다면 선호하는 대상은:

*a. 전부 한국어*        *b. 한국어 위주*    *c. 한국어/영어 반반*    *d. 영어 위주*
        *e. 전부 영어*

## 건강 상태

*귀하의 건강 상태에 대하여 해당되는 답에 동그라미를 쳐 주시기 바랍니다.*

2. 전반적으로 나의 건강 상태는:

**최상이다     아주 좋다     좋다     무난하다     좋지 않다     아주 나쁘다**

5. 현재 건강 상태가 탁자 옮기기, 청소기 사용, 볼링, 골프 등의 적당한 활동을 하는데 얼만큼 제한하나요?

   *많이 제한함          약간 제한함          전혀 제한하지 않음*

6. 현재 건강 상태가 여러 계단을 오르는데 얼만큼 제한하나요?

   *많이 제한함          약간 제한함          전혀 제한하지 않음*

7. **지난 4주동안**, 신체적 건강 상태로 인해 직장 업무나 일상적인 일의 능률이 감소했나요?
   *예          아니오*

13. **지난 4주동안**, 신체적 건강 상태로 인해 직장 업무나 일상적인 일을 하는데 제약이 있었나요?
    *예          아니오*

14. **지난 4주동안**, 정서적인 문제(우울감, 불안감 등)로 인해 직장 업무나 일상적인 일의 능률이 감소했나요?
    *예          아니오*

15. **지난 4주동안**, 정서적인 문제로 인해 직장 업무나 일상적인 일을 하는데 평소보다 덜 신중했나요?
    *예          아니오*

16. **지난 4주동안**, 신체적 고통이나 통증이 귀하의 직장 업무나 일상적인 일을 하는데 얼마나 방해하였나요?

    *전혀          아주 조금          어느정도          많이          아주 많이*

17. **지난 4주동안**, 차분하고 평온했던 시간은 얼마나 되나요?

    *항상          대부분          적당히          가끔          없음*

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18. **지난 4주동안**, 활기찬 시간을 보낸 기간은 얼마나 되나요?

*항상        대부분        적당히        가끔        없음*

19. **지난 4주동안**, 낙담하거나 우울했던 기간은 얼마나 되나요?

*항상        대부분        어느정도        가끔        없음*

20. **지난 4주동안**, 신체적, 정서적인 문제가 사교 활동을(친인척 방문 등) 방해했던 시간은 얼마나 되나요?

*항상        대부분        어느정도        가끔        없음*

## 탄성력(Resiliency)

*귀하의 탄성성을 나타내는 답에 동그라미를 쳐 주시기 바랍니다.*

11. 나는 변화에 적응할수 있다.

*전혀 아니다   드믈게 그렇다              가끔 그렇다   자주 그렇다         항상 그렇다*

12. 나는 어떤 일이든 감당할수 있다.

*전혀 아니다   드믈게 그렇다              가끔 그렇다   자주 그렇다         항상 그렇다*

13. 나는 어려움에 직면할때 상황의 유머스러운 면을 보려고 한다.

*전혀 아니다   드믈게 그렇다              가끔 그렇다   자주 그렇다         항상 그렇다*

14. 스트레스에 대처해 나가며 나는 더 강해질수 있다.

*전혀 아니다   드믈게 그렇다              가끔 그렇다   자주 그렇다         항상 그렇다*

15. 나는 병이나 부상, 고난 등을 겪은 뒤에 회복이 빠른 편이다.

*전혀 아니다   드믈게 그렇다              가끔 그렇다   자주 그렇다         항상 그렇다*

16. 나는 어려움 속에서도 목표를 달성할수 있다고 믿는다.

*전혀 아니다   드믈게 그렇다                    가끔 그렇다   자주 그렇다              항상*
*그렇다*

17. 나는 압박감 속에서도 맑은 정신력과 집중력을 유지한다.

*전혀 아니다   드믈게 그렇다                    가끔 그렇다   자주 그렇다              항상*
*그렇다*

18. 나는 실패로 인해 쉽게 낙담하지 않는다.

*전혀 아니다   드믈게 그렇다                    가끔 그렇다   자주 그렇다              항상*
*그렇다*

19. 나는 삶에 어려움과 고난에 대처할때 내 자신이 강한 사람이라고 생각한다.

*전혀 아니다   드믈게 그렇다                    가끔 그렇다   자주 그렇다              항상*
*그렇다*

20. 나는 고통, 슬픔, 두려움, 분노 등의 불편한 감정들을 감당할수 있다.

*전혀 아니다   드믈게 그렇다                    가끔 그렇다   자주 그렇다              항상*

*그렇다*