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Shannon Yambasky
Korean Cultural Narratives of
Depression

ABSTRACT

This qualitative exploratory study examines the Korean cultural narrative of depression from Korean American clinician's perspectives. There were eight participants that were licensed in one of the following professions; marriage and family therapist, licensed clinical social worker, psychologist and psychiatrist. The participants provided their understanding from a Korean cultural point of view, as well being able to compare and contrast it to the western diagnosis of depression. The goal being to provide clinicians working with Korean individual's greater knowledge and insight so they may have a more culturally competent practice.

Study results indicated that within the Korean culture there is shame that is attached to acknowledging depressive symptoms within the culture; because the culture is still very collectivist, shame from an individual reflects the family as a whole. Participants expressed that Korean individuals will speak of physical ailments, somaticize symptoms of depression instead of speaking of sadness or low moods; contrary to how depression is expressed and diagnosed by westerners.

KOREAN CULTURAL NARRATIVES OF DEPRESSION

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Northampton, Massachusetts

2013

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This thesis is dedicated to my little sister, whose strength and courage to stay true to her self inspires every ounce of me, and who I am forever indebted to for her love and friendship.

First and foremost, I would to thank the eight clinicians that participated in this study for sharing their, stories, understandings, insights, and taking time to participate.

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To the love of my life, without you, this would not be. You are my foundation and I have been blessed by your kindness, love, support, and graciousness as we walked along our path.

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CHAPTER I

Introduction

“Most people commit suicide because they have trouble communicating and feel isolated. So this bridge will make people feel they are wanted and help them open up”

Park Young-Ki, of the Korea Suicide Prevention Group (Strother, 2012, p.2). This quote is from an article that discusses how South Korea is putting up inspirational slogans, pictures of babies, and endearing statues of family members, on bridges all over South Korea. The South Korean government is taking actions such as this specifically on bridges which have been a frequent place for suicide in the country.

Korea has been reported as having a significant increase of suicide within the country. The New York Times has run articles interviewing psychologists in South Korea to try understand why it is documented that 30 South Koreans kill themselves every day (McDonald, 2011).

In 2008, a South Korean actress Jin-Sil Choi’s sudden death was recognized as suicide. Her suicide was widely reported in the press and gained a great deal of public attention throughout the country. This actress was viewed as an idol and role model for young adults in Korea. Because of this suicide, Korean government agencies began a nationwide discussion of depression. According to a report from the Korean Doctor’s Association written in 2008; “there are 38 people who commit suicide every day in Korea, and 70% of these people are diagnosed

with depression” (Park, 2011, p. 14). With the high number of suicides in Korea, and governmental and media attention, the concept of depression and the substantial effects of this mental state are now focused on in Korea.

Western clinicians working with Korean American clients or clinicians that go to Korea to practice should make sure they have an understanding of depression from a Korean cultural perspective. Social workers should be knowledgeable about their clients’ cultures, or clinicians should educate themselves if a new client comes from a different background. Social workers should be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups (National Association of Social Workers, 2012). The following research will provide a resources for clinicians working Korean clients; in hopes that clinicians will work within social work ethics and practice cultural competence.

This research will explore Korean cultural narratives defining depression as articulated by Korean American clinicians. Once these narratives have been described through a qualitative method using 8 interviews, the interviewer asked how each clinician integrates these narratives into their clinical practice. Utilizing Korean American clinicians, varying perspectives were provided; first, from a Korean point of view on the cultural understanding of depression. Second, researching how the Korean understanding differs from a western understanding of depression. For the purpose of this research, I defined the Korean American clinician as one who was born in Korean and practices here in the United States, as well as 2nd and 3rd generation Korean Americans clinicians where a clinician was born in the U.S. but their parents were born in Korea. I have defined my research questions as: What are Korean cultural narratives of depression from the perspectives of Korean American clinicians? This question is the basis of this research.

This research increases empirical understandings of how depression is defined and understood culturally in Korea, and how to better service Korean American clients. By utilizing a sample of 8 Korean American Clinicians, this research helps us gain insight about depression from those who identify with the Korean heritage, as well as a greater understanding of western definitions of depression. With both a Korean and Western understanding, participants can speak to the difference and similarities in views of depression.

It is important for social workers to value not only the medical western view of mental health, but also consider the roots and history of how a particular culture understands mental health. As social workers, we should consider the effects of the western mental health system on other cultures and be cautious that Western ideas do not contribute to a loss of cultural identity and beliefs. Ethan Watters (2010) states in his book, *The Globalization of the American Psyche*, found that a particularly “Americanized version of depression is on the rise in countries across the world” (Watters 2010, p. 2). This author documents his travels around the world that look at the influence of American mental health culture on countries; taking a careful look at how western healers can often overlook indigenous beliefs about mental health and treatment.

Mr. Watters dedicates a chapter in his book to his research around how depression came to be such a highly medicated illness in Japan. The chapter starts out by Mr. Watters interviewing a professor named Dr. Kirmayer. The chapter details the Dr. relating his knowledge about Japan and depression, in the early 2000’s, psychiatry in Japan focused almost exclusively on the severely mentally ill. Western forms of talk therapy were almost nonexistent in the country. At this time there was a psychiatric term for depression, *utsubyo*, what is referred to be a mental illness that was chronic and devastating and would require long stays in mental hospitals. At this time no word in Japanese had the same connotations as the word for depression in

English. Keeping in the description of the early 2000's, there were drastic growing rates of suicides in the country; and "services were in the midst of a critical change. There was a "burgeoning concern in the population about how mood disorder and the need for social attention to suicide rates and depression" (Watters 2010, p.193). Dr. Kirmayer also noted that the western definition and symptom checklist for depression was slightly starting to follow the Western DSM.

Mr. Watters reflects upon how a suicide changed the fate of depression medication in Japan from there on out. A young single Japanese man living with his parents got a reputable job at a notable advertising company in Japan. At this point in his life, peers saw the young man as healthy, athletic, outgoing, and happy. Because of an economic downturn in Japan shortly after his hire, this young man's job became particularly demanding. This individual would stay at work all hours of the night to get the job done, and his parents became particularly concerned about his well-being. Less than a year into this job, the individuals seemed like a completely different person; unhappy, shameful of any mistake he made, and exhausted continuously. One day this individual called the office to tell them he was sick, and committed suicide less than one hour later. The parents sued the company their son worked for and won their lawsuit. This lawsuit was highly publicized in the country and highlighted the high number of suicides within the country. This also started a shift in the understanding of depression, it was now something that could hit anyone; the country was spilt on if this new form of depression caused suicide, or the old beliefs that suicide was a moral or philosophical intently act.

The complete shift in Japan's attitudes and approach to depression came after a natural disaster. After this disaster pharmaceutical companies from the west joined forces and launched an advertising monster into main stream media in Japan for their mood alternating drugs

regularly prescribed for depression. The drug companies did not focus on their particular medications, but paid for public services announcements that encouraged individuals to seek help for their “depression.” They craftily marketed to the professionals that would be doing the prescribing in Japan. Japanese professional Kitanaka, is quoted as being “stunned to see how fast things have changed in in Japan since the SSRI was introduced. The whole culture surrounding psychiatry has changed drastically; from a stigmatizing condition that no one talked about, to depression being one of the top concerns of people. It has become a legitimate disease at so many different levels and at the same time these changes have transformed the nature of depression as an experience (Watters 2010, p. 245).

This piece of journalism regarding the shift in a cultural view of depression in Japan, and Japans high suicide rates, is not to say that Korean will take the same path, but it is important because it paints a picture of how cultural beliefs can be shifted by powerful forces and how it is important to understand how a culture experiences an illness.

The following research is dedicated to documenting the cultural understanding of depression from a Korean point of view. This research was conducted to better equip clinicians for culturally competent practices, and to provide a greater understanding of the experience of depression from a Korean cultural context.

Social work is bound to the ethics of understanding cultural diversity and how one’s culture influences behavior. Further developing research on depression from a Korean perspective and how this is applicable in treatment is at the core of this research. It is hoped, that this research will further develop social workers understanding of the cultural narratives of depression from a Korean American clinicians perspective, and how do these narratives influence their clinical practice.

The following chapters will include; literature review, methodology, findings, and discussion. The literature review chapter will focus on past research that pertains to Korea and depression. The methodology chapter will detail the process of conducting this research project, as well as how specifically the data was collected. The findings chapter will outline the responses to the specific interview questions that were asked to participants in the research, and the discussion chapter, will discuss the relevance of the finding and link them to literature from the review.

Chapter II

Literature Review

The goal of this study was to gain greater knowledge from Korean American clinicians about Korean cultural narratives about depression. Korean American clinicians will not only be able to discuss their understanding of Korean perspectives of depression, but also compare and contrast it to the western conception and diagnosis of depression. The goal being to provide clinicians working with Korean individual's greater knowledge and insight so they will have a more culturally competent practice. Literature is limited, and an aspect of the differences between Korean symptomology of mental illness and lack of mental health utilization in Korea is just starting to be documented through research. For the purpose of this review, the literature will be broken up into three sections; 1) Korean culture, 2) Korea and Japan, 3) Korean depression; barriers to utilization of mental health services, symptomology and acculturation.

Korean Culture

Culture plays an important role in how individuals perceive their environment and develop. Starting in infancy, the prevailing cultural model articulates to the person which physical and emotional sensations, changes, and experiences should be acknowledged and articulated (Arnault, in press). For his dissertation, J. Park (2011) has provided extensive quantitative research around the subject of mental health in Asia, specifically in Korea. This author concluded that, "traditionally Asian Americans try to resolve their problems on their own, believing that mental health can be maintained by avoiding bad thoughts and exercising will

power” (p. 2). Specifically, Koreans with mental illness are often discouraged by family members from seeking mental health services; this may be because it is a belief that utilization of mental health services would ruin the family honor and bring shame on the family. Therefore, Koreans do not usually share their family and personal matters with those outside the family (Sin, Jordan, & Park, 2011). Koreans and Korean Americans tend to describe mental illness as having a spiritual cause, and this does not differ according to Christianity, Animism, Shamanism, or Confucianism; which are the four main sources of spirituality in Korean culture (Park, 2011). Because of this, mental ailments are viewed as a personal characteristic, not as psychologically based.

The philosophy of Confucianism is deeply rooted in the minds of Koreans; which strongly affects their thoughts and behaviors. There are five principle of Confucianism that have been identified in research; 1) harmony between husband and wife, 2) order between elders and juniors, 3) trust among friends, 4) loyalty between subjects, and 5) autonomy and deference between husband and wife. Korean values have emphasized that persons should strive to be interdependent and emphasize harmony with others instead of competition (Park, 2011). Because of these deeply rooted beliefs, “Koreans see themselves as members of a group.” In reactions to this, “people who need assistance usually look first to their family members” in the Korean culture (Pang, 1995, p. 4-5). This ideal could create barriers to Korean individuals seeking out mental health services, because these services are normally given by individuals one does not know. Also, in the Korean culture “people feel shame for bringing ‘dishonor’ onto the family. Admitting to feelings of depression may arouse shame” (Pang, 1995, p. 5). With suicide rates at a very high level in Korea, if fact Korean is the ranked number one among developed

countries, the concept of depression is surfacing, but traditional Korean values might deter individuals from seeking services (Park et al., 2010).

Korean and Japan

Japan and Korea have similar ideologies, both are considered to be Confucian countries and have similar social values (Inglehart, 2000). Japan has been seen as a role model that Korea must catch up with in terms of levels of modernization (Goodman & Peng, 1996). Both countries experienced an economic recession in the late 1900's (Targum & Kitanaka, 2012). Also, Japan and Korea have both experienced suicide rates that increased drastically in the last couple of decades, with Korea having the highest annual suicide rate currently, and Japan the 3rd highest. (Targum & Kitanaka, 2012). With both Japanese and Korean cultures being very traditional, it has not been easy "to acknowledge the relationship between suicide and depression, but the enormous social and economic consequences of the deaths have fostered an unusual partnership between the government and psychiatry to try and confront this urgent bio-social issue (Targum & Kitanaka, 2012, p. 35). Literature on why suicide is increasing in Korea is extremely limited and empirical studies on depression are just beginning to emerge; in contrast Japan seems to have been given more empirical attention in research.

Scholars such as Junko Kitanaka, have written extensively on Japan, depression, and suicide. An interview that is in an article by Targum (2012), the interviewee Kitanaka reports that the concept of suicide has been changing over the past hundred years in Japan. Previously, Japanese tended to view suicide as an act of individual freedom, and there was an expression in Japan that referenced suicide as being an act of resolve. With the suicide rate skyrocketing over the past decade, these ideas have been challenged.

Kitanaka (2012) further elaborates that, currently in Japan a new concept has emerged that suggests that suicide results from tremendous social pressures and depression. Now in Japan, old ideas around suicide are being replaced by broad- scale social medicalization of suicide. The term medicalization is a process whereby a problem of living is redefined as a psychiatric pathology. The suicide crisis has facilitated the acknowledgment and recognition of depression as a problem in Japan; whereas depression was thought of as a rarity in Japan many years ago, the shift in the concept of suicide as a product of mental illness has facilitated the use of mental health services for diagnosis and effective treatment of depressive disorder. Kitanaka (2012) in his book *Depression in Japan* states;

The rapid success of medicalization of depression in Japan is due in large to psychiatrists' successful attempts to change the terms of the debate regarding psychopathology. In dissemination of a new medical model of depression, they have combined physiological, neurochemical accounts with social, existential narratives that place it in both a scientific and experiential illness category. Particularly through their successful de-stigmatization campaigns, psychiatrists have emphasized that depression is not a genetic weakness or a psychological problem but a physiological disease- a 'cold of heart' that one becomes susceptible to when placed under excessive stress (p.179).

These changes have created a shift in how the Japanese conceptualize depression; Japanese psychiatry and social ideals of depression are moving away from traditional perceptions toward a more Western view.

According to Kato et al. (2011), beginning around 2000 "Japanese psychiatrist have increasingly reported patients with depression that does not seem to fit the DSM-IV criteria, and which is widely denoted as 'modern depression (MTD)'" (p. 67). Kato et al., (2011) conducted

an empirical study to investigate the frequency of MTD in Japan and other countries. The study conducted an international questionnaire survey through the Japanese Society of Psychiatry and other international networks. Participating were psychiatrist and psychiatric residents of nine countries including Japan. The questionnaire was self-administered and the contents were two case vignettes; case A was a vignette that was a representation of a traditional Japanese depression type, and case B was a representation of MTD. The participants were asked to evaluate the following items using a five point Likert scale; frequency of the case in participants own country (rarely/often), cause, diagnosis, suicide risk and treatment plans (psychotherapy, pharmacotherapy, ect). The sample participants included, 34 from Korea, 22 from Australia, 19 from Taiwan, 10 from Bangladesh, Iran, India and USA, 9 from Thailand, and 123 form Japan. Overall, both of these types of depression were considered to exist in all countries. This study concluded that the current DSM criteria may not be sufficient to diagnose MTD. Studies like this indicate there it is a need to understand other cultures, their narratives about mental illness, and have culturally relevant diagnostic tools in order to remain culturally competent clinically. The limitations of this study were a small sample size and sampling bias of mainly young psychiatrist from limited areas in each country. The strength of this study was that the participants were all psychiatrists with thorough knowledge of depression form their cultural point of view.

As mentioned prior, Japan and Korea have a similar Confuses background. It is important to note that just because there are similarities between these two Asian countries does not mean that suicidal rates and depression are the same. Research by S. Kim et al (2011) has concluded that different patterns of suicide epidemiology have evolved in Korean and Japan, and there are different distributions of suicide methods in the two countries. What makes these finding significant to my research is the concept that the two Asian countries may have very

different experiences when it comes to depression and suicide. While literature has explored Japan in regards to suicide and depression, it does not mean Korea has the same experience of these two conditions.

Korea and Depression

An exact word that represents the American version of depression in Korea has not been found. In fact studies that have focused on highly distressed Koreans have identified several syndromes that resemble depression. Arnault and Kim, (2008) discussed three relevant Korean concepts,

1) *han* (a form of regret or resentment syndrome), 2) *hwa-byung* (an anger syndrome), and 3) *shinyungshyak* (an emotional psychic and bodily disorder). *Han* has been described as a passive, chronic regret and resentment syndrome and includes the sensation of an obstruction by lump in epigastric and respiratory regions. *Han* also includes expression of dysphonic effect, such as self-pity, commonly associated with disappointments and unfulfilled aspirations. *Hwa-byung* is the most widely studied Korean depressive-like bodily disorder. It sometimes described as anger syndrome that encompasses elements of depression, resentment, somatic illness and neurotic symptoms.(p. 28-29). *Shinyungshyak* is an emotional psychic and bodily disorder characterized by fatigue, depression, feelings of inadequacy, headaches, hypersensitivity to sensory stimulation, and psychosomatic symptoms such as digestion disturbances and insomnia.

Very few studies have focused on the specific array of symptoms in these depressive states according to Korean and Korean Americans. Research that focuses on depression and its

manifestation is important to understanding how Korean culture experiences and expresses depression.

Literature about Korea and depression has just begun to emerge in the last decades. Some of this research looks at stigma and barriers to mental health service utilization. M.S. Roh (2009) focused on factors that affect treatment for depression and the dispositions towards treating depression. The study chose 7,357 medical students in Korea because they are educated in psychiatric illnesses and have easily available access to mental health services at their educational institutes. The study was guided by 2 questions. The first question was, which socio-demographic factors and what type of history of diagnosis (history of treatment, dispositions towards depression) are associated with treatment for depression among Korean medical students; the second question was which area of knowledge about mental health problems is associated with medical student's seeking treatment? This study was cross-sectional, and a nationwide survey was sent to all medical students (n=14, 095) enrolled in 41 medical schools in Korea. Of all the students who received the survey, 52.2% (n= 7357) completed the survey and had their data included in this analysis. The questionnaires asked for data on students socio-demographics, if there was a history or current diagnosis of depression, history or a past of treatment for depression, and dispositions towards and any knowledge of mental health problems; the survey also included the Beck Depression Inventory. The questions used to evaluate dispositions towards using psychiatric services or taking psychiatric medicine were: 'if you had a mental health problem, such as depression, what would you do; if you were advised to take an antidepressant by your doctor, what course of action would you take? Students were considered disposed to seek psychiatric services when they answered; 'if I had a mental health problem, such a depression, I would seek psychiatric services. If students answered 'if I were

advised to take an antidepressant by my doctor, I would take it without concern,' those students were considered disposed to take pharmacotherapy. The survey also gathered two areas of knowledge; knowledge about the etiology of depression, and knowledge about psychiatric medicines. To evaluate this knowledge the survey asked, 'what do you think depression is caused by, and what do you think psychiatric medicines such as antidepressants are like?'

In the category of, characteristics associated with treatment for depression, of the 7357 respondents, 689 were identified as being depressed. Of the depressed respondents, 61 had either a history of or current diagnosis of depression, and 67 had a history of or were receiving treatment. For knowledge and disposition to use psychiatric services, students who had a history of diagnosis or treatment for depression has a 2.1 fold higher rate of being disposed to seek psychiatric services than students who did not have such a history. The statistics for all categories follow the pattern that, if a student has any prior knowledge, history of depression or have previously used psychiatric services, they are pre disposed to seek services. Overall the findings show that Korean medical students frequently experience depression, but few of these students seek treatment for their problems, and many go undiagnosed. Also, knowledge of the etiology and treatment of depression is relevant to students' attitudes towards seeking mental health care for their depression (Roh et al., 2009). Many times Koreans do not define their maladies in terms of a mental illness, and because of this they do not seek assistance from these types of helpers (Pang, 1989). This is research that supports the idea that Korean do not seek outside assistance for their mental ailments, specifically depression. The strengths of this studies was its large sample size, the limitations are that the results could have been distorted because those individuals who chose to respond might have responded because they have positive attitude towards mental health services. My study will continue to research attitudes about

mental health, specifically depression, but will elaborate on why Korean individuals might not seek treatment. It is a qualitative study which looks closely at Korean narratives about depression.

Another, study done in Korean, Russia, and the United States focused on comparing attitudes about depression in these countries. This study's aim was to demonstrate cultural differences in attitudes about depression and corresponding treatment. This study utilized primary care facilities in three clinics in the state of Iowa in the US, a medical academy in Russia, and three primary care clinics in a hospital settings in Korea. This is a descriptive study based upon a survey that was presented to individuals while they were seeking care in the three different countries. Individuals that choose to participate were given a 38 question survey reflecting questions about attitudes about depression. A five point Likert scale that started at 1 (strongly disagree) to five (strongly agree) was used. According to the researchers, "the presence or absence of significant cultural differences was examined by conducting chi-square analysis comparing the USA, Russia, and Korea on each of the five point Likert scale questions" (Turvey, Jogerst, Kim, & Frolova, 2012, p. 1645).

The results showed that Koreans tended to rate themselves less healthy than those residing in the USA or Russia. In all three countries, the majority of participants endorsed that depression is a kind of disease, but the USA and Korea were more similar in their answers than Russia. This pattern held true for the questions describing a medical model for depression. In contrast, Russia and Korea similarly endorsed items that reflected depression as a personal weakness. In the US only 6% believed that having depression means that a person is weak, while a significant majority in Korea and Russia endorsed this belief. This study did demonstrate that culture influences beliefs about depression by showing the similarities and differences among the

participants in their endorsements of specific statements about the nature of depression. The limitations of this study lies in the convenience sample of volunteers at the selected primary care clinics. There is no way to determine how well this sample represents the larger populations of these countries. Also the Russian sample was much smaller than that of Korea and the USA (Turvey et al., 2012). Even with these limitations, the results that depression is seen as a personal weakness by Koreans is comparable to other studies, and further highlights the need for research on depression and Korea. This following research will continue to investigate the perception of depression, but will ask more in-depth questions about why Korean might perceive depression in a certain way, for instance as a Weakness.

Research by Ina et al (2010) has looked specifically at certain groups in Korean and assessed for depression. A study was conducted to examine the prevalence of screening-detected depression and if there was an association of depression with the quality of life in community dwelling postmenopausal woman living in three Asian countries. Depressive symptoms were assessed using the geriatric depression scale (GDS)-15 item scale. The results found that Korean subjects reported problems with pain/discomfort and anxiety/ depression were higher in Korean subjects (Ina et al., 2010). A limitation of this study was that the sample size was different in the three countries; there were 300 Korean participants, 336 Chinese participants, and 62 Japanese participants. The strength of this study was how it looked at a very specific population, community dwelling postmenopausal woman, and found risk factors of depression. The current research will further elaborate on the “pain and discomfort” part of the above study; noting if this may mean a physical pain or discomfort.

Nam, Kim, Lee, and Kim, (2011) conducted a study that aimed to explore predictors of depression. They used a convenience sample of 767 employed women from the Seoul and the

Kyunggi Province of Korea. The study selected 283 participants who were identified as being depressed using a cut off of >9 for the Beck Depression Inventory (BDI). This cut off point would include a mild syndrome of depression. In this study, Korean versions of the Self-Efficacy Scale, the Schedule of Recent Life Event/Recent Life Changes Questionnaire (SRLE/RLCQ), and the Beck Depression Inventory; were all translated into Korean and provided evidence of good reliability. The Self- Efficacy Scale is a 17-item tool with a five-point Likert rating system. The SRLE/RLCQ was developed to assess the number of stressful life events that have occurred over the last 6 months and how a person perceives the intensity of these events. The BDI consist of 21 items and it assesses the level of depression. A Hierarchical multiple regression analyses were used to test for depression predictors. Of the 283 participants, depression scores ranged from clinically mild to moderate depression according to the Beck Depression Inventory, in numerical terms this was 10-51, with a mean of 14. High amounts of Stressful life events, lack of closeness to family and friends, older age, and minimal daily hours for housekeeping were significantly correlated with depression. The results from this hierarchical multiple regression analyses explained the predictors of depression. The authors of this article acknowledge that depressed individuals, when faced with stressful life events, may be unable to cope.

Psychological and physiological resources had direct effects on depression in the study. If a participant indicated having the psychological resource of self-efficacy, those participants also reported themselves as less depressed. In this study, the researchers did use exercise as a variable, but the findings are unexpected; “unlike expected, the results indicates that women who did regular exercise reported a higher level of depression than those who did not exercise” (Nam, Kim, Lee, & Kim, 2011, p. 142). This finding is counter intuitive. In the west, exercise is encouraged when an individual is feeling down; this might not be an appropriate suggestion to a

Korean client. This study highlights cultural differences of mental disorders and how interventions must be culturally appropriate.

One limitation of the study was involved the perceived level of closeness. This questions asked how emotionally close a woman perceived herself to be with whoever the woman identified as the person she was most closely connected to. Most participants reported their intimate person as their husband. The authors noted that in Korea, married men rarely express their feelings of emotional closeness to their wife; and thus married Korean women may not feel emotionally supported by their husbands. The study results indicate that interventions targeting employed women in Korea should focus on strengthening resources (in regards to self-efficacy), and improving health behaviors while empowering connectedness at the same time. This study highlights how interventions must be culturally appropriate, and what may be predictors of depression for Korean American women. The current study will highlight what is important to know about Koreans and depression and not just speak to a woman's point of view.

Korean symptomology of depression

Early studies on depression across different cultures indicated that the cluster of symptoms characterizing depression in the West seems to be rare, or absent in non-Western cultures (Chang, 1995). Symptoms of an illness contain a network of meanings for the sufferer: this includes the experience of personal traumas, life stresses, fears and expectations about the illness, social reactions of friends and authorities, and therapeutic experiences (Pang, 1998). Taking a look at how depression affects one and how these symptoms are articulated in a specific cultural is immensely beneficial to clinicians who are working with clients from a culture they might not be familiar. There is some literature that has sought to understand the symptomology

of Koreans in regards to depression, and the following empirical studies have results that work towards a foundation for this understanding.

Arnaault and Kim (2008) created an empirical study to research if there is an Asian Idiom of Distress; meaning is there a culturally specific experience of suffering? This research aimed to examine the relationship between culture, self, distress, and depression. A convenience sample of junior and senior undergraduate and graduate students attending classes in psychology in Tokyo Japan and nursing classes in Seoul, Korean were invited to participate. Those who choose to participate were given a packet of diaries and were instructed to complete the diaries once a day for a total of 7 consecutive days. The depressive symptomology was measured by the Beck Depression Inventory. Physical symptoms were measured by a modified version of the Pennebarker Inventory of Limbic Languidness (PILL). This is a 54-item scale that measures the common physical symptoms of a group and evaluates the intensity. An ANOVA comparisons for the BDI scores revealed that there was not a significant difference between Japanese and Korean BDI scores. For somatic symptoms, there was a positive correlation between somatic mean scores and BDI scores for both sample groups. The authors wrote,

The study revealed that about half of the somatic symptoms endorsed by the women from the two Asian countries were the same. Interestingly, gastric and abdominal upset, weakness, dizziness, aches and pains, and palpitations were endorsed by high- BDI women in both countries. Indeed, these findings provide partial support to the notion that Japanese and Koreans may share something Asian and that this may also influence idioms of distress. Finding similarities in distress profiles in wide cultural regions like Asia may help busy practitioners narrow down all of the possible cultural differences in distress in their patient groups....The differences between the somatic symptoms for the

Japanese and the Korean woman were subtle but noteworthy. The high BDI Japanese group had higher means for headache, numerous neurological symptoms, cold hands and feet and shoulder pain. The Korean high BDI woman has more cardiac and neurological symptoms.

In conclusion, if Asians in general, Korean and Japanese women in particular, have important somatic distress that tends to signal difficulties in functioning, poor quality of life, and/or depression, this must be a focus in the work. The somatization of depression was noted by this study in both countries, but again there were differences; because of these difference further exploration and understanding of depression in regards to Korea is needed. We also must be careful not to uncritically apply the western psychological theory that significant physical distress is a result of having a difficult time with verbal expression of emotions (Arnault & Kim, 2008).

Pang (1995) notes that in the United States the Diagnostic Interview Schedule (DIS-III) is used to diagnose mental disorders and the questions reflect the DSM-III criteria for major depression. It has been noted that in regards to Asia, there are short comings of western tools such as the DIS-II. The Korean Diagnostic Interview Schedule (KDIS) is designed expressly for Korean Immigrants and is a modified version of the American DIS-III. The Semi-Structured Korean Interview Guide for Depression (SKIGD) is designed expressly for Korean immigrants. This tool asks a series of questions related to how one is adapting to old age, adaptation to immigration, experience of sadness or depression, and experience of Korean popular illnesses. Generally this questionnaire takes about 3 hours. Pang (1995) conducted a study to test these diagnostic tools. The sample frame in this study was elderly Koreans over 60 living in the Washington D.C area. The Korean versions of diagnostic tool assessed depression for more

participants than western tools. Implications show that culturally relevant tools for depression are needed when working Korean immigrants.

This study also conducted interviews that noted the somatic experience of depressed individuals. One participant was quoted as saying,

When I got upset in distress, some phenomena struck me persistently that made me feel as if my shoulders were sagging under heavy pressure and burdens. When it was severe, I was ill and lay down in my bed for three days.”

Another participant stated that she suffers from poor vision, “my eyes are just the problem. I don’t have particular problems. I just can’t see things freely because of my eyes. This women scored as depressed in this study, but stated to the interviewer that is was her vision. The strength of this study was the large sample size that was gathered through the snowball method. Another strength was the mixed method design of the study. The limitation of this study involved that fact that the ‘depressed sample’ had more female participating and had less education. This research highlights how it is of utmost importance when working with immigrants, specifically Koreans, to know how symptoms may be described from this cultural point of view. The current study will fill in the gap of comparing and contrasting the Korean symptoms of depression to the Western diagnosis of depression.

Pang (1995) goes on to further explain that in cultures that tends to somatize mental suffering, many are willing to admit their physical suffering but are not ready to admit to depression. Bernstein et al (2008), qualitative research has identified three reasons for somatization by Koreans:

a) traditional Eastern medicine conceives disease as based upon a presumed like between psychological and physical functioning, and emotional distress therefore tends to be

projected on the body; (b) medical practice among Koreans is a somatic, body-orientated practice; (c) a cultural emphasis on maintaining harmony within groups and in relations leads to a cultural norm of suppressing one's personal emotions to avoid confrontation (p. 15).

These findings further support how depression is understood and manifested for Korean individuals may be different from the West.

In another study by Bernstein et al (2008,) the researchers worked with Korean Immigrant women suffering from depression in order to study the cultural specific symptoms of their depression. The sample was gathered by placing an advertisement in a Korean- language newspaper that appealed to Korean immigrant women suffering from depression. Twenty responded and 17 were found to have depression using the Korean version of the Hamilton Rating Scale for depression. The study was conducted over a 10 month period with face to face interviews. Participants were asked to describe their experience using their own language; the interviewers were bi-lingual. It was “uncovered that participants used the word ‘suffering’ more commonly than did the term ‘depressed” (p. 396). There were several themes that were elicited from depression symptom manifestations. The four major ones were emotional entrapment, shame and failure as a women, disappointment and failure to live a normal life, emotional restraint, somatic bodily and metaphoric expressions. A somatic symptom was a ‘clogged up chest’ and identified with suffering, and it was found that;

Participants rarely expressed their emotions verbally but instead described their feelings somatically, bodily and metaphorically. Participants often claimed that their bodies knew when there were emotional problems, leading to aches and pains, generalized bodily

weakness and feeling sick all the time with no apparent medical diagnosis. They realized that their emotional problems were expressed through physical ailments (p.399)

This is very different from how depression symptoms are manifested in the United States which tends to be related to feelings and emotional state of sadness. The limitations of the study are that the sample was only in the New York area, and the investigators did not explore differences in symptom expression and manifestation (Bernstein et al., 2008). Strengths of this study included utilizing a Korean version of a scale to measure depression. The current study will utilize participants from different cities throughout the United States.

Yoo and Skovoholt (2001) conducted a comparative study in order to attempt to better understand cross cultural difference between American and Korean cultures regarding depression and its expression, and help seeking behaviors. Specifically the authors looked at differences in depression symptomatology and attitudes towards seeking psychological help and the relationship between somatization tendency and attitudes towards seeking professional help among Korean and American students. The participants were 88 undergraduate students enrolled at either UCSB or UM (University of Michigan) in the United States, and 95 undergraduate students enrolled at Seoul National University in Korea. Class instructors introduced the study and American students were given \$10.00, while Korean students received no compensation. A questionnaire was given in class for Korean students, but American students were given the questionnaire and able to complete at their convenience. The expression of depression was measured by the Center for Epidemiological Studies-Depression Scale (CES-D). This is a self-report instrument intended to identify symptoms associated with depression, the Korean version has been assessed for validity. Help seeking behavior was measured by the Attitudes Towards Seeking Professional Help Scale, (ATSPHS), which has 29 items that utilized a 4 point scale (1

strongly disagree to 4 strongly agree) describing to what degree a particular statement applies to the individual. The Korean version was translated into Korean and cross-validated with translation instruments. When assessing the difference of depression expression between the two country samples, a multivariate analysis of covariance was performed using each item of the CES-D as a dependent variable. This test indicated that there were significant differences in the groups on how depression was expressed. It was demonstrated that Korean students reported more somatic symptoms than American students such as having a poor appetite, feeling like everything is an effort and talking less than usual. The results also indicated that the more participants somaticize their depression, the more negative they were about seeking professional help. The strength of this study was that it showed the specific differences of depression symptom expression in the two different countries. Despite the efforts of the authors, the instruments are still considered a limitation. The authors stated that the somatization of Asian cultures of depression needs further research.

The current study will fill in a gap in literature by providing a more extensive explanation on the somatization of depression by Koreans.

Acculturation and Immigrant from Korea

There is a large population of Korean Americans in the United States and this has stemmed from three waves of Korean immigration. The first was around 1903-05 with 7,394 Korean individuals immigrating to the US, then in 1950-1964 the second wave of Korean people immigrated and these numbers were around 17,000. The third, and largest, wave started in 1976 because of the Immigration and Nationality Act Amendment of 1965 and 30,000 Korean individuals immigrated to the US. Because of these waves, a large number of Korean Americans

reside in the United States (Park, 2011). Increased depression symptoms are one of the most prevalent mental health problems among Korean Americans (Kim, 2011).

The acculturation experience greatly impacts Korean Americans' perception of mental health (Park, 2011). Pang (1995) reports that the ideal family dynamics in Korea do not mesh comfortably with American norms. Bernstein (2008) reports most immigrants that arrive in the US arrive with different cultural norms, language and value systems. As they try and adapt to their new environment they often experience what is termed acculturative stress, and studies have shown acculturative stress can contribute to immigrants exhibiting depressive symptoms.

Kim (2011) researched what are the "links between intergenerational acculturation conflict and parent's depression symptom and what are the specific intergenerational acculturation conflict situations that are related to parent's depression" (Kim, 2011, p. 688). This study engaged 176 Korean American parents and used a correlation study design. This study used the Asian American Family Conflict Scale to look at acculturation conflict and the Center for Epidemiologic Studies for Depression scale to assess for depression symptoms. There were positive links between fathers' and mothers' report of intergenerational acculturation conflict and their increased depression symptoms. The intergeneration acculturation conflict scale looks at the frequency of Asian American parent-child conflicts in ten typical disagreements over values and practices. Understanding this added level of emotional conflict when working with Korean American parents as clients in the United States is another important element to understanding a client's biopsychosocial context. Research such as this is necessary for clinicians to better understand depressive symptoms from a Korean point of view.

Acculturation stress for Korean immigrants may contribute to depressive symptoms. What is also important to understand is how these depressive symptoms are

expressed and experienced based on the history and norms of Korean culture. Researching what Korean American clinicians note about Korean narratives of depression and the similarities and differences from a western perspective will further lay ground work for a more cultural competent framework when working with Korean clients. As mentioned, it is hoped that this study will provide further tools for clinicians working with Korean clients to remain culturally competent. Cultural competency as a concept is fairly new to the social work field (Lu, Lum, & Chen, 2001). Theories and understandings of this concept have proven their importance to helping professions as a whole. The importance of becoming culturally competent clinicians has been widely researched and supported by the social work profession. The concept of becoming a culturally competent clinician involves being aware of the combined impact of cultural, ethnicity, gender, and environment on an individual's development. It has been researched that clients are more satisfied with clinicians when they perceive the practitioner to be culturally competent, compassionate, and able to understand a client's world view; now necessarily when they feel ethnically matched (Comas-Diaz, 2012). Understanding of a client's cultural is key in the actual helping process because cultural defines the problems prospective, the expression of the problem, and the treatment options (Lu et al., 2001). There is a theoretical foundation within cultural competency.

The framework of cultural competency theory involves four criteria to work from: "(1) awareness of ethnic and cultural experiences that are integral part of the personal and professional socialization and education of the social worker; (2) knowledge related to culturally diverse practice; (3) skills related to working with culturally diverse clients; (4) inductive learning that forms a continuum of heuristic information on culturally diverse persons, events, and places" (Hong, Strokes, Byoun, Furuto, & Kim, 2013, p. 182). According to this theory,

clinical knowledge is the foundation for cultural competency; therefore social workers must incorporate their clinical skills to fit them for a target population. This research will provide tools for clinicians working with Korean clients to maintain a culturally competent practice

The literature in regards to Koreans and depression has a reliable foundation because these studies were able to find samples of Koreans in Korea as well as Korean Americans. Previous research has looked at different sub populations of Korean to document and research expression and perceptions of depression. Research focusing on specific sub groups of Korean can be beneficial to clinicians if they are working with this population. One of the limitations of prior research is that there is not much qualitative data; only statistics that describe depression from a Korean point of view. Qualitative data looking at Korean cultural narratives will be able to further explore the personal understanding of depression. The current study will do just that. Utilizing the sample of Korean American Clinicians, this study will explore the in-depth meaning of depression, the symptomology, the perception, and treatment, through in depth questions about these subject matters. The current study; will fill the gap of the need for qualitative research looking at Korean cultural narratives about depression.

The following chapter will discuss the methodology of how this qualitative research around Korean narratives of depression was conducted.

Chapter III

Methodology

The purpose of this qualitative research study was to explore and describe the cultural beliefs and narratives of Korean people concerning depression from the perspective of Korean American clinicians. Eight Korean American clinicians were interviewed for approximately one hour. The participants in this study were all Korean American licensed clinicians. The therapist did not have to be currently practicing, but must have had at least a graduate degree and be licensed in the state they reside.

By choosing a qualitative design, I was able to engage participants in open-ended questions that explored: 1) What is the Korean cultural understanding of depression, and how is depression expressed and experienced from a Korean perspective? 2) Is depression experienced in Korea differently from the western DSM diagnosis of depression? 3) What is important for clinicians working with Korean individuals to understand in regards to depression? I extensively explored literature for this project and found no similar prior similar study.

Sample

Eight (n=8) licensed clinical social worker, marriage and family therapists, mental health counselors, psychologists or psychiatrists were interviewed for this qualitative study. These participants also identified as Korean American. Korean Americans were defined as either individuals born in Korea who moved to the United States and/or first, second or third generation Korean Americans. First generation is defined as individuals who are the first to be born as

American citizens; descendants from parents who were immigrants. Second generation is defined as the offspring of first generation individuals; thus continues in the same pattern for as generations continue. All participants had to fulfill both the clinical and Korean American requirements to be included in this study.

There were five demographic questions (age, gender, years in practice, professional license, and generation of Korean American) asked at the beginning of each interview followed by 12 open-ended questions that sought to explore the three research questions mentioned above. The demographic questions included what profession each participant was licensed in and what generation of Korean American the participant identified with; as clinicians answered both of these questions, it was confirmed the clinical and cultural requirements for this study. Each participant was asked the same 12 interview questions, but the participants were given the freedom to answer and explore how they choose.

Of the 8 Korean American therapists, five (63%) identified as female, three (37%) as male. Participants' age ranged from 27-62. There was one (13%) clinical social worker, three (37%) marriage and family therapist, two (25%) psychologists, and two (25%) psychiatrists. Number of years practicing ranged from 4-32. There were four (50%) first generation, and four (50%) second generation clinicians that participated.

Figure A

Generation of Korean American Participants

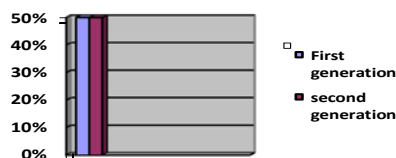
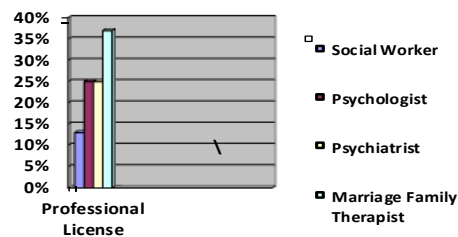


Figure B

Professional License of Participants



Interviewing each participant gave me the chance to hear their personal cultural narratives, for instance what they might have experience with family and friends in regards to Korean attitudes about depression. Interviewing Korean American clinicians gave me the unique opportunity for participants to compare and contrast the western perspective of depression with the Korean perspective.

After I received approval from the Human Subjects Review Committee via an approval letter (Appendix A), I began recruitment for the study. I gathered participant in three different ways. I contacted former colleagues to participate, and asked these colleagues to help me begin a snowball sample with their professional network (Appendix B). I asked my former colleges to forward my recruitment letter (Appendix B) to those they believe would meet the criteria for my study. I then emailed individuals who identified as a Korean American therapist on a bay area therapist directory to recruit (Appendix C) for my study. Those who were interested in participating contacted me via email; in the email I asked the participant to confirm that they were eligible for the study via the requirements that were defined in the recruitment emails. We

then set up a confidential and convenient place to conduct the interviews. Five interviews were done in person and three were conducted via the telephone. All interviews were recorded on a Livescribe, which is pen that records, as well as lets one write notes on a Livescribe note book that are linked into the recording. I then transcribed by myself.

Risk and benefits of participation

Participation in this study provided participants with an opportunity to further research on Korean culture and depression, which could lead to more culturally competent clinical practices with Korean clients in the future. By participating in this research, clinicians had the unique experience to not only be involved in research that will be beneficial to their profession, but potentially beneficial to Korean Americans as a whole. During the interviews participants took a look at and talked about, how their culture influences their clinical practice. This may have led to new insights; participants may never have used this lens of examination and could inspire participants to become more active in research regarding Korean culture and mental health. Participation may have also highlighted the need for Korean American focused agencies and groups and perhaps participants may be inspired to develop such programs.

This present study presented little risk to participants. However, participants were asked to reflect upon personal and family narratives which could have created emotional discomfort. At the beginning of the interviews, participants were made aware that they have the right to refuse to answer any questions in the interview with no consequences. Participants were also made aware that at any time in the interview, they may state that they do not wish to continue and I would stop the interview immediately. At that time, any recording will be erased, the informed consent destroyed and all emails deleted. Participants were told that they cannot withdrawal after

April 16th after which the write up for this study will begin. Because the participants in this study are clinicians no referrals to outside mental health resources was needed.

Data Collection

At the beginning of each interview that was conducted in person, I handed the participant the informed consent form (Appendix D) and asked that they read it carefully and relay any questions they might have to me at that time. If the participant chose to sign to consent form, we begin the interview and began to record it. If the interview was conducted on the telephone, I mailed the participant the Informed consent (Appendix D) and asked that they read it carefully, let me know of any questions and send the document back to me with their signature. A return self-addressed envelope was provided. In both situations, participants kept a copy of the consent form as well.

The interview started with five demographic questions which included; age, gender, what profession they are licensed in, how many years they have been practicing and what generation Korean American are they (Appendix E 1-5). Then there was a series of 12 open-ended questions (Appendix E 6-16); examples are, how is depression defined in Korea, or how is depression assessed or treated in Korea? All participants were asked the same interview questions. At the end of each interview, I took the last five minutes to thank the participant for their time and remind them that they have my contact information and the Smith School for Social Work if they have any questions or concerns. No names or identifying information was used for participants, agencies or clients. Since the participants were mental health providers, I did not need to provide a list of mental health services where a participant could receive emotional support after the interview.

After completion of all eight of the interviews, I personally transcribed the interviews into a word document.

All data will be stored locked on my computer and informed consents will be stored in a locked file cabinet for the three years as required by Federal regulations. After the three years they will be destroyed unless needed for further study, in which case they will continue to be kept secure for as long as needed.

Data Analysis

For this study, I used content analysis to explore the data gathered in the interviews. Content analysis focuses on the meanings, intentions and contexts contained in messages (Prasad 2008, P.3). I personally transcribed the interview and turned them into a word document. With the word document, I was able to begin to code the interviews. I identified commonalities, intersectional ties, and distinct difference between participant's responses. The results from my data analysis will be discussed in the following chapters, the findings and discussion sections of this thesis.

The strengths of this research were found in the sample of participants gathered. Because the objective of this research was to document Korean cultural narratives, utilizing participants that identified with their Korean cultural, participants could really relay what they have experienced about their Korean culture. Also utilizing a qualitative method gave the participants full range to really explore and respond to each interview question; each participant had the freedom to speak about what they felt was important to understand about Korea and depression. Using content analysis of the data, I was able to compare and contrast answers of each participant to each question; this is a strength of this research, the similar answers showed how people from all different socioeconomically factors have the same cultural understanding of

depression. The similarities and differences of answers will be detailed in the findings chapter. Some of the limitations of the study were that there were only eight participants; gathering a greater number of participants could have increased the validity of the findings. Also, the majority of the participants spoke Korean and I do not, if I was privy to the language I might have been able to explore the interview questions on a deeper cultural level with participants

CHAPTER IV

FINDINGS

The purpose of this study is to gain insight from Korean American clinicians about Korean cultural narratives concerning depression. Korean American clinicians can report their understanding of a Korean perspective of depression, but also compare and contrast it with the western conception and diagnosis of depression. Utilizing clinicians who identify with their Korean heritage, this study explored symptoms, perceptions and treatment of depression in Korean culture, how the concept of depression has changed over the years in Korea; and what is important for clinicians working with Korean clients to understand. The goal being, to provide clinicians working with Korean individual's increased knowledge about the Korean culture leading to a more culturally competent practice. Each participant also identified where they believe research should be directed in regards to Korean and Korean Americans and mental health.

Demographic Data

There were eight (n=8) participants in this study. Five (63%) identified as female, three (37%) as male. Four (50%) of are first generation Korean Americans and four (50%) are second generation Korean Americans. Participant's ages ranged from 27 to 62 years. Of the eight participants, three (38%) were clinically trained as Marriage and Family Therapists (MFT), one (13%) is a licensed clinical social worker, two (25%) are licensed psychologist, and two (25%) are psychiatrists. All participants identified as having knowledge of their Korean heritage.

Definition of depression and its symptoms

Participants were first asked to define depression from a Korean cultural point of view. There were a range of responses. Participant one believes that there is a stark difference between Korean beliefs about depression and the western diagnosis and symptoms. In Korean culture symptoms tend to be more somatic; “Koreans are not going to conceptualize depression in the same way as the DSM conceptualizes depression, often somaticize it. So with depression one might complain of headaches, stomachaches, indigestion.” Participant two referred to a specific type/syndrome of depression, and similarly spoke about somatic symptoms.

When Koreans say depressed, they mean like a hopelessness and stuck, and there is common notion about depression. Culturally, it is Han, which is culturally based syndrome; if you look at the DSM four there is Han appendix section. So that is anger, things of that matter, are part of it. Han is especially from a female point of view, there is so much Han because they are suppressed. Korea is a male driven society, so Han, is expressed by women because they are not really able to get what you want and it comes out as yearning for something. Han is part of depression, but not all of depression. Somatic symptoms will be how depression manifest with Koreans, well they complain about body ache, sleeping problem, damn indigestion, my medical doctor is wrong because he thinks nothing is wrong with me. Externalization.

Participant five, elaborated on the symptomology of depression having somatic tendencies, but defined depression in different terms of weakness.

Depression is defined as having a weak soul or mind. Many Korean are religious (mostly Christian and Catholic) and sometimes believe that the devil is weakening the soul to interfere with one's spiritual growth.

In general, it is more common for Korean Patients to manifest their depression through physical symptoms such as headache, stomach pains, and fatigue, rather than connecting with their emotional state of mind.

Participant three and four had similar answers in regards to depression being weakness of the mind for Korean individuals; participant four:

It's considered, a weakness, you know and hmm, I think the folks that present with the most severe depression they are not hesitating to take medication for it, like anti-depressants. In terms of considering it a psychological disorder they don't. It is more of a medical condition. A weakness.

Participant three elaborated on how gender plays a role in the acceptability of depression, but confirmed that weakness is the definition; specifically stated that Korean men are not to have weakness, this will lead to shame.

Weakness of mind. For woman, I see it is more acceptable to see it as a weakness of mind. But for men it is a shameful thing, shamed to not talk about those things, man up. I think a lot of pressure is put on Korean men when they admit that they are struggling, there is a strong sense of shame attached to it, as it goes against what they were taught most likely, sign a weakness, it might be a very long struggle to open up those thing.

Participant seven believes depression is not acknowledged because it would acknowledge sadness, sadness is not acceptable in the Korean culture. Participant seven talks about how negating sadness may lead to the promotion of anger;

Depression is not emphasized in the Korean culture because of it is sister, “sadness,” is not acknowledged. The emotion that is most often appears is anger for some reason, anger is an acceptable emotion. As a culture, we are trained to be angry at those who have oppressed Koreans historically, particularly the Japanese. But to show weakness, as sadness and depression, isn’t acceptable.

Whereas participant eight has a unique perspective and believes that the Korean and Western concepts of depression are very similar, but in Korea it is not attributed to biology:

“I think it is defined the same as it would be here in terms of change of mood. Someone feels down and sad; the part that is not well known in Korean culture is that depression can be biologically based. There is not a good understanding of that. There is more of an understanding of depression being a transient thing, based on stresses in one’s life, more of a personality type than it being biologically based.”

Participant Seven distinguished the externalization of the disease in the Korean culture compared to the internalization from a western view point; “if you were to state a symptom, we as Koreans would view it as ‘because we are Korean’ verse Americans who would view it as happening to isolated people.”

Perception

When participants were asked if depression was discussed in their family of origin (Korean), many had similar answers, and shared their personal stories. Their answers articulated the perception of depression from a Korean understanding. Participant two shared how

depression is not talked about in the Korean culture; this participant has family members that are suffering from depression, but there is no conversation about depression specifically.

Korean culture as a whole does not talk about depression. I see a lot of people that could benefit from therapy and medication but a lot of people don't go for help (speaking of Korean and Korean American individuals). Even in our family I see the resistance to therapy, my sister is business woman and was professionally successful, but then decided to retire. She has in the past, and continues to have somatization of her depression, talking about body problems. I know she is depressed, but me as a brother, she will not listen to. She has been depressed for over 20 years, for the first time she acknowledged she has a problem was a week ago. I am going to retire soon, so I will start my private practice, she asked why I will continue to work. I responded to her that I am afraid if I don't have anything to do at home; I am going to be really depressed. Then guess what, she tell me about it. She still doesn't go all the way there, but we talked.

My family doesn't even know what I am doing as a licensed clinical social worker, even though I tell them. I explain to them in detail what I am doing; at one family gathering my nephew said I work with homeless people. They think I am a teacher because I teach them how to be happy.

Participant six shared her family experience around not acknowledging depression and mental illness, how this lack of acknowledgement was based on shame.

Mental illness, such as depression, was not discussed in my family. There was a lot of stigma behind having a mental illness or seeing a mental health provider. People with depression were considered "weak-minded," or people with psychosis were filled with the devil. When one of my cousins was diagnosed with bulimia, there was a lack of

understanding and compassion from my Korean family. My family members blamed her illness on my aunt that was raising her “wrong” and believed she should just stop her bulimic behaviors as if she could control it. Going into psychiatry was not a “respectable” medical field like surgery or internal medicine and my family actually urged me to switch specialties at one point.

Participant three shared a heartbreaking story about how depression is perceived as something you do not talk about as a Korean. This lack of acknowledgment of depression and suicide lead to family secrets.

My father and younger brother both committed suicide; they were both angry men. To my grandmother’s death two years ago the suicides were hidden, only to save face for the family. The story was that my father was successful in America; my cousins that are younger than me do not know that their uncle committed suicide. It is such a shameful thing. The men are supported to be seen as leaders, if there is weakness like that is shames the family.

When discussing with participants their family experience and conversations concerning depression; the notion of shame came up quit often. Participant five felt that having depression would bring personal shame to them and their family; overall in the Korean culture shame is very present.

A lot of the ideas of personal shame, or bringing shame on your family, because of actions seem to be stronger in Korean cultural at large. There defiantly is a sense of responsibility, you are not just a single individual, you reflect on you entire family. In fact my parents grew up in Korea and came here for graduate school and a long time in Korea and then in the United States, in fact I remember one time when I was in high

school or something, sometimes my parents would get confused about the pronouns plural and singular; they speak English very well, my mom said once there was not that same kind of distinction. Because American culture is so much you are an individual, I took that to mean Korean cultural there is a sense of collectivism, sense of being part of something.

Participant seven agrees with participant five that in the Korean culture an individual is viewed as a part of a group, not a solo person; “the difference is that for Koreans, if you were to state a symptom we would view it as, ‘because we are Korean,’ verse Americans who would view it as happening to isolated people.” This participant further stated that “to show weakness, as sadness and depression is not acceptable.”

Participant one elaborates on how there is a taboo/stigma around depression because shame is correlated with the illness, and this shame reflects your group.

There is still a taboo around mental illness because shame is a big factor. Still relative is that Koreans come from a collectivist cultural, so how others view you and how you are perceived is important for the group. Now there are not that many villages in Korea but they still have that mentality. So, hmm, it just reflects badly on your family, they want to guide you; if they you seek out mental health services they are likely to be secretive about it

Participant four talks about how it is shameful to have depression and how it is seen as something the person with the illness has done.

I think for the most part it is shameful. What fucked up thing in your family do you have that you have to be depressed? Hmm, I think people are more knowledgeable now. But I

got a lot of messages that therapy and things like that is a luxury. Just to talk about silly things, self-absorbed people

Weakness, shame, and lack of acknowledgment about depression were the main themes from this part of the interview.

Treatment

When participants were asked about treatment for depression within a Korean cultural context, a few participants (n= 3)(37.5%) stated answers similar to participant one's "I would say they would use herbal products, acupuncture and Chinese medicine." Also by asking about treatment, I came across an interesting fact about Korean spirituality that I had not received from the literature that was read for this project. A large part of the how depression/mental illness is first attempted to fix is through family talk, then to a spiritual leader. This occurs only if an individual supposes the stigma of admitting to their feelings of depression. All of the participants that referred to the spiritual leader as the cure spoke about Korea and the large Christian population that resides. Participant one elaborated on how this came to be.

Like, at night you will see a lot of red crosses. Because 150 yrs. ago American Christian missionaries came to Korea, somehow they made a big impact; they introduced health clinics, things like that, practical things. There was a lot of conversion. Another thing was Korean language was invented in the 1400, Rak, Sejeong king was part of this invention, up until that time the real written language was Chinese characters; we were influenced by China. The leader devised the written system for the common folks, the literate people would insist on using Chinese. So written language was Chinese, but common folks spoke in Korean. But when the missionaries came they helped to revive the Korean language, written language because they needed to translate the bible, so all

of a sudden the literacy rate of the common folk, and that is when the Korean Language became more widely used. Yeah so that is one reason why the Koreans became more Christianized, 45 % Christian. Well what is interesting is there is a lot of shamanism and Buddhism embedded in the Christian faith.

Participant three followed up with the spiritual treatment for depression in regards to the Christina influence.

A lot of Koreans, well the difference between Korea and other east Asian cultures is Christianity is very big, so what I have seen is the first thing that gets put in is see the pastor. And ok, then maybe you are not spiritual enough, depend on God more. When working with Koreans, one of the first things I will ask is if they are connected to a church. That is because the Korean cultural is so intertwined in the church, whether they are religious or not.

Participants five noted the same alignment with Christianity, “There is also a more spiritual part about it”

Contrasting the above views was participant six’s answer to treatment of depression. This participant believed that the treatment is evidence based, much like the United States: “it is very evidence-based and similar to the U.S. I went to Korean and Japan in 2012 to participate in a psychiatric workshop for Korean and Japanese psychiatrists. They are very scientific in their approaches to assessment and treatment of depression with many more medications than the U.S.” This was very interesting to hear, and correlated with others clinicians about how Korea is changing in their perception of mental illness and treatment.

How understanding of depression has changed in Korea over the years

Participant six referenced how this evidence based method might be because of the westernization of Korea in the recent years; “I do believe it has become more westernized. As mentioned, Korea has become very evidence-based in their approach to treating depression, often following many of the guidelines set in the U.S.” Two participants (25%) spoke about how the concept of depression and mental illness is changing in Korean, but Korean Americans and older generations of Koreans, are still set on the traditional mindset. Participant one believes that looking at the generational difference is important when thinking about how to work with Korean clients. “You also want to look at generational difference. The older people are more likely to utilize traditional medical services. I think the younger people are more likely to mental health type services. Like where they go to school, there might be counseling services.” Participant two supported this notion; and defined it as the country of Korea may be changing, but immigrants from Korea may still have older mindsets of depression, ” Koreans in the United States are probably still more backwards, we are still caring the culture of that we brought from Korea, I see that a lot of people don’t seek counseling.” When participant three was asked about the changes in Korea in regards to depression they believed that the country of Korea is being westernized, but 2nd generation Korean Americans may still have an “old school” thought around depression.

I think it is now; the weird thing is now the 2nd generation has firmer values for old school ways, Korean traditions, because of when they immigrated. In Korea a lot has been westernized so a lot of values have changed. I have friends that have moved back to Korea and work in the mental health field, where as people who are a little older, the concept of mental health was not there. But now it is gradually opening more, I can see it

in my aunts, they are more open to talking about things of that nature, they want to see a therapist, counselor, whereas 10 yrs. ago no way

It is interesting that participant eight notes the same years about when westernization began in Korea, but contrast the above thoughts slightly by still believing there is not much assessment still in the country: “yes there is not much assessment; psychotherapy is still very much in its infancy in Korea. There is not much of a concept of psychotherapy in Korea. It has changed a little bit. I think it has changed in the past ten years. The availability is not wide spread; I don’t believe that insurance covers psychotherapy. The availability is very limited. Affordability is limited.” Participant two attributes some of this change to the same type of educational programming as we have here in the United States on local T.V., “depression has changed over the years because of TV, media, that promote psycho education, and they have a program where a medical doctor talks about symptoms about GI problems, and then talked about depression; a lot of educated people watch this and acknowledge that there is a mental illness, depression, and acceptance of depression is changing in Korea,”

Cultural Competence with Korean Clients

A very important and noteworthy part of this study was what each Korean American clinician thought would be important to understand about Korean clients to be more culturally competent clinicians. I will list, and group each response according to similarities in answers for the reader to acknowledge and reflect upon when working with Korean clients. Participant two, six, seven, and eight, all talk about how understanding the Korean culture of depression is very important. Participant two and seven speak to the importance of understanding how the tabooess of depression is important to understand.

Participant 2, I think we have to really be aware of cultural aspects, really aware of tabooess of having depression, and more so, really utilize psycho education for Korean population in general. Right now, help them to work with depression, accept the fact of depression and that it is not a debilitating illness if you work at it, you have to give them hope.

Participant 7, Koreans are known to be impulsive. Perhaps there is something about depression or sadness that gives us time to process between shock or trauma and moving on. For Koreans, because of being sad, and particularly sadness that immobilizes, is not acceptable, we are forced into action and that action is often fatal to self and others. You hear stories of fathers who kill themselves and families because their business is failing. You can't understand depression in Korean culture without knowing the prevalence of domestic violence and substance abuse. Depression is often drowned in alcoholism and gambling. The work culture in Korea almost requires drinking large amounts of alcohol daily. Depression among women is also often linked to the high percentage of Korean women who are in the churches. Women tend to seek faith as an answer to their depression.

Following that, participant six, speaks to how it is important to know about the ways depression might manifest itself in Korean patients, and participant eight, speaks about how it is important to understand that Korean individuals might still see treatment for depression only for severe cases.

Participant 6, it would be most important to understand that depression can manifest in different ways in Korean patients. Sometimes they don't present with the classic depression symptoms we learn about. Korean patients I have worked with mostly isolate

themselves and complain of somatic symptoms (fatigue, headache, low appetite). Suicide is a serious issue. Often they do not talk about suicidal feelings and when they attempt suicide, it is well planned and lethal. Being patient and compassionate is a key treatment. There may be lingering stigma attached to being diagnosed or treated for depression making it difficult to work with the patient. Education and normalization of depression can be an effective way to get patients to comply with treatment. Teaching them depression is just like having hypertension, diabetes, or cancer, I try to normalize just another medical problem we deal with. Koreans tend to value religion and its role in their lives. They usually seek help from their religious leaders and often made an association between their religious conflicts and depression. It would be beneficial for clinicians to be aware and respectful of their religion and how it affects their understanding of depression. Sometimes working with the religious leaders and finding positive coping strategies through their religion (prayer, meditation, reading Bible, attending church, etc.) to deal with depression can be helpful.

Participant 8, the concept of treatment in Korea is very much that it is based on the idea that it is for only severe psychopathology such as psychosis. Depressions, unless it was of the very severe kind, where a person was attempting suicide, people would not routinely think of it as something that required treatment, or psychiatric attention.

Participants one and four talk about how understanding Korean family dynamics is important when working with Korean clients.

Participant 1, Understanding the big picture and seeing it all. Look at family relationships and take that into account. I try to work personally work with the family as much as possible; it is very common for Korean patients to be connected in some way with their

family. Even into their 30 and 40, if fact technically in the Korean cultures you is still a baby till you get married. It is very common to still, my wife has friends that are in their 40s and still live with their parents, not married. Be aware of family dynamics and see if they are connected to one of the family members, see if you could get the clinician to work with that member, if possible. Most therapists just focus on the individual but I think for Koreans is still a very interdepend culture. Be aware of also their spirituality and religious beliefs. When I talk with certain clients I don't shy away from using their language so find common ground.

Participant 4- Well I think one of the things to be culturally competent with Koreans is to understand the hierarchy in the family. being also understanding their world view which is a more collectivist, and harmonious, verses individualistic, how is this going to shame your family, how is this affects your mom and dad. Who are you going to rely on for support? Which generation are you, how acculturated are you?

Participant three and five talk about how psycho education, and furthering research for the purpose of education for clinicians, is important to understand in regard to Korean individuals.

Participant 3, I would say the biggest thing is educate, letting people know that it is ok, letting people know it is an illness. Try to break across the barrier that is an illness, still to a degree seen as weakness.

Participant 5, One thing for treatment is I know with the anti-psychotic medication may need a lower dose and may be more prone to side effects, research about the difference on how different population respond to medication. It would be interesting to see how Korean Americans that are in treatment came to treatment. Was it the traditional referral patterns western clients do or was there some way they got into the system that was

different? Where they more inclined as many depressed people to first contact their primary care provider. Are there differences in the way they access the system. What different kinds of psych therapy may be useful, I would have not hypothesis how that would go, would they be more CBT type of treatment be less reviewing or when they are able to establish that relationship. Are different kinds of treatments more successful?

Each one of these eight responses offers a unique perspective as to what is essential to think about when working with Korean individuals; this also leads to the complexities of working with clients from cultures that as a clinician one might not be familiar with. That is why this research is hoped to provide further empirical tools for clinicians as they work with Korean clients.

In the following discussion chapter, V, these findings will be further discusses and the themes will be noted, addressed, and linked to literature.

Chapter V

Discussion

This study was conducted to explore the various narratives about depression from Korean American clinicians who strongly identify with their Korean cultural heritage; clinicians were used as participants so that each individual interviewed would also have training in the western diagnosis of depression. These participants were used as a sample in hopes that the clinicians could articulate differences and similarities that they perceive within an understanding of depression from a Korean cultural context verses a Western view point. This study set out to understand the definition, symptoms, perception, treatment, and changes in Korea, in regards to depression from a Korean point of view. Interview questions were tailored for responses in each category. The interviews also explored what Korean American clinicians believe is important for clinicians working with Korean clients to understand about Korean culture and depression to better service their client. The purpose of this study was to provide research findings that will provide resources for clinician working with Korean clients to help them to be more culturally competent as there have been limited studies that focused on the Korean understanding of depression.

Demographics

The demographics in this study were not noteworthy. All participants identified as Korean American, either first or second generation, and because they all believed that they really

could speak to their Korean heritage, this was an ideal sample. There were no notable differences between first and second generation Korean American clinician's responses. In a women dominated professions, such as MFTs and Psychologist, a little over a 1/3 of the participants were male (n= 3). Having this many males participants was unexpected, and added a gender component to the narratives of depression from the interviews. Participants ranged from 27 to 62 yrs. old, offering interview responses from individuals in a range of life stages and career experience. The age range did not seem to affect the participant's attitudes or narratives on a particular way. Participants came from three major cities in the United States, all which have been illustrated as Korean Immigration hubs through immigration research.

Depression symptoms

The findings of this study primarily confirmed research findings from prior studies on depression manifestation in Korean and Korean Americans; studies noted the somatization of depression symptoms in Korean individuals (Arnaault & Kim, 2008; Bernstein et al, 2008; Pang, 1995; Yoo & Skovoholt, 2001). Of the eight participants, four (50%) spoke directly about somatic symptoms that Korean individual will have when depressed, these somatic symptoms will be verbalized rather than a discussion about emotions. This research result highlighted how it will be important for clinicians to think about Korean client's physical complaints when assessing their emotional state.

Depression Definition

In this research four (50%) participants described depression according to their Korean cultural heritage as weakness of mind or soul. Participants elaborated, that to have depression means one is weak in the Korean culture. This thought of depression as a personal weakness

supports research by Turvey, Jogerst, Kim, & Frolova, (2012); which found that Korean culture reflected depression as a personal weakness. Three (37.5) participants believed there is not a definition for depression in Korea. One of these three noted Han, “culturally based syndrome, anger and things of that matter” (participant 2), as a syndrome like depression in Korea but not actually depression; and another of the three, directly stated that there is not a definition, at least nothing that would correlated to the DSM. Both answers support research done by Arnault & Kim, (2008) which define Han as a syndrome of regret and resentment, but also these authors identify that there is not a specific illness in Korea that would be considered what depression is according to the western conception.

Treatment

In this research, three (37.5%) of participants noted that Koreans do not talk about feelings of depression or sadness with others; therefore they do not seek treatment or believe in treatment; this is similar to other research that addressed the same ideas (Sin, Jordan, & Park, 2011). The research and this study concluded that as Koreans, you just try to solve your problems on your own. If one does decide that they would like assistance for their problem with mood; they will speak to family or clergy, negating medical advising. This may very well be correlated to the next section of perception of individuals with depression.

Perception of individuals who experience depression

The findings of this study primarily confirmed research findings from prior studies on depression and how Korean and Korean Americans perceive depression as shameful (Pang, 1995; Park, 2011; Sin, Jordan, & Park, 2011). Of the eight participants, six (75%) spoke about how Korean individuals feel shame for their weakness (depression). The similar findings of

previous studies and the current one, shows how it is very important for clinicians to understand and explore the sense of shame that a Korean client might feel about admitting and receiving help for their depression.

The same research mentioned above noted that admitting this shameful state (depression) would bring shame on one's family or group. All six participants (75%) spoke about shame being attributed to one's family/group. This idea supports Pang (1995) who stated "Koreans see themselves as members of a group." Korean "people feel shame for bringing 'dishonor' onto the family. Admitting feelings of depression may arouse shame" (p.4-5). Therefore from past research and this current study, there is a pattern; people feel a sense of weakness for depressive feelings, they do not talk about it because it might evoke shame, and therefore no treatment is obtained. This cyclical pattern is an area where further research is needed. I also believe that if you are a clinician working with a Korean clients, it is so very important to understand how much a client might feel just admitting to their struggles is very difficult, let alone receiving treatment.

Four (50%) of the participants noted that if Korean individuals do seek help, they will usually go to a religious leader (usually a pastor) for their symptoms of depression. Each of these participants noted the importance of Christianity in the Korean culture. I believe that this spiritual element is very important for clinicians to understand. First, as a clinician, if you are treating a Korean client, they may have exhausted all other avenues and may see you are their last hope; or you might not be viewed as individual that can really help. Also, it is important to understand how Christianity is laced throughout the Korean culture, and not assume clients ascribe to Buddhism.

Change in Korean perception of depression

All of the eight participants noted that the perception of depression is changing within the Korean culture, and this was thought to be happening because of the Westernization of Korea. Three (37.5) participants supported previous research (Bernstein, 2008; Kim, 2011; Park, 2011; Pang, 1995) which states that it is very important to take a look at acculturation, immigration and generation when considering where a Korean individual might fall on the changing spectrum of depression. The three participants agreed that if a person in a Korean immigrant in the United states they may have 'old world view' of Korea, but in Korea thoughts about depression and mental illness are shifting and becoming more open to different perceptions. Pang (1995) agrees with the participant views but also speaks to how Korean immigrant's family dynamics do not mesh well with the typical western family dynamics; this can cause stress for these individuals. Korean American parents may struggle with their children overly adapting to western views, this can also cause stress and depressive like symptoms according to Bernstein (2008) and Kim (2011). All of these elements of immigration and acculturation are import to further study, but to also think about when working with Korean American clients.

Conclusions

Thorough this study, and past research, it has been noted that there are some important cultural aspects of the concept of depression from a Korean point of view. One of important notions is how Korean individuals may somaticize their feelings of sadness. They may directly speak about physical symptoms, such as body aches, and not open up about how they feel sad. This research found, any Koreans feel that speaking about sadness means an individual has a weakness in them. Admitting this weakness would cause the individual shame, this shame would not be attributed to the person themselves only, but to the group which they belong to

(family). It seems that according to research, if a Korean individual was to seek help for depression, they would look to their spiritual leader, mainly their pastor for guidance. Alternatively, this current study found they may also look to traditional Chinese medicine. These aspects of the Korean culture would be important for a clinician to understand when working with Korean clients.

As mentioned above, the strengths of this research were found in the nature of the participants and the qualitative format. Utilizing Korean American clinicians lends to an interviews that explored not only a perspective of depression from a Korean cultural view, but also how this differed or compared from western ideas of depression from a professional perspective. Utilizing the qualitative method to gather data gave participants an open space to really reflect upon how they would like to answer each question. The limitations included I do not speak Korean and there may have been information that was lost in just English interview questions and answers; also, that there were only eight participants in this study. A greater number of participants could have further validated understandings of depression from a Korean cultural point of view, or contrasted with different perceptions.

Implication for research, policy, and practice

Further Qualitative research that continues to explore Korean cultural narratives is needed. This type of research can really begin to explore the nature of how Koreans culturally view the depressive state. Studies done in Korea would further the need for a Korean cultural understanding of depression. There is also a need for research that looks to understand immigrants of Korea in America and how their depressive symptoms may be related to stress of acculturation and parenting first generation children.

In social work schools it is important to highlight the importance of clinicians remaining culturally competent with their clients. Not only should schools provide overview on how to be a culturally competent clinician; but a step further would include, classes that speak to specific cultures understanding of mental illness and health

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Appendix A

Human Subjects Committee Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 22, 2013

Shannon Yambasky

Dear Shannon,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett" followed by a flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

Appendix B

Recruitment Letter For Snowball Sampling

Dear Colleague,

My name is Shannon Yambasky. I am currently working with excitement on completion of my Master's thesis at Smith College School for Social Work. I am writing to ask for your participation in my explorative study that looks at Korean Americans and depression.

The focus of my study is gathering Korean cultural narratives in regards to depression; this study will involve questions about your understanding of depression from a Korean point of view as well as from a western point of view. This study is not aimed at defining one concept of depression as right or wrong but is intended to gain a better understanding of depression within a Korean cultural context; in hopes to produce research that works toward clinicians having resources to become more culturally competent when working with Korean and Korean American clients.

You are considered eligible to participate in my study if you are Korean American. A Master's degree or MD in one of the following professions: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychology, or Psychiatry is also required. It is important that you identify as having personal knowledge and/or professional experience in regards to depression as it is experienced in the Korean culture.

Participation in this study will include an approximately 60 minute interview that will involve a series of open-ended questions. . If you chose to participate, we will work together to find a time and location that is both convenient and confidential for this interview to take place.

If you would like to participant in this study please contact me by email and phone number, then we will begin to work on times and days for your interview. Also if you have colleagues, friends, or family that meet the criteria for this study please **forward this letter** to those individuals.

By participating in this study, participants will be furthering research that may help to create more culturally competent practices for clinicians working with Korean and Korean American clients.

If you have any questions about my research or the nature of your participation, please feel free to email or call me at ----- or ----- If you reply to this email please be cautioned not to "Reply all," please just respond to the above Smith email.

Thank you so much for your time and interest in my research topic!

Sincerely,

Shannon Yambasky

MSW Candidate, Smith College School for Social Work.

Appendix C

Recruitment Email for Community Therapist Listed in Online Therapist Directories

Dear Colleague,

My name is Shannon Yambasky, I am currently working with excitement on completion of my Master's thesis at Smith College School for Social Work. I am writing to ask for your participation in my explorative study that looks at Korean Americans and depression. You are receiving this email because you have identified yourself as a Korean American therapist in the Bay area on a local therapist directory.

The focus of my study is gathering Korean cultural narratives in regards to depression; this study will involve questions about your understanding of depression from a Korean point of view as well as from a western point of view. This study is not aimed at defining one concept of depression as right or wrong but is intended to gain a better understanding of depression within a Korean cultural context; in hopes to produce research that works toward clinicians having resources to become more culturally competent when working with Korean and Korean American clients.

You are considered eligible to participate in my study if you are Korean American. A Master's degree or MD in one of the following professions: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychology, or Psychiatry is also required. It is important that you identify as having personal knowledge and/or professional experience in regards to depression as it is experienced in the Korean culture.

Participation in this study will include an approximately 60 minute interview that will involve a series of open-ended questions.. If you chose to participate, we will work together to find a time and location that is both convenient and confidential for this interview to take place.

If you would like to participate in this study please contact me by email and phone number, then we will begin to work on times and days for your interview. Also if you have colleagues, friends, or family that meet the criteria for this study please **forward this letter** to those individuals.

By participating in this study, participants will be furthering research that may help to create more culturally competent practices for clinicians working with Korean and Korean American clients.

If you have any questions about my research or the nature of your participation, please feel free to email or call me at ----- or ----- . If you reply to this email please be cautioned not to "Reply all," please just respond to the above Smith email.

Thank you so much for your time and interest in my research topic!

Sincerely,
Shannon Yambasky

Appendix D

Informed Consent Paperwork

Dear Participant,

My name is Shannon Yambasky, and I am a graduate student at Smith College School for Social Work. I am working towards my MSW and conducting research for my thesis. This study will explore Korean cultural narratives about depression; looking at how depression is perceived and experienced within the Korean culture. The research is intended to ultimately assist clinicians working with Korean individuals to be more culturally competent.

To participate in this research you must first identify as Korean American and be either born in Korea and/or first, second, third generation Korean American. You must also be a licensed clinician in one of the following professions: Clinical social worker, marriage and family therapy, psychologist, or psychiatrist. You must have at least a graduate level of education, your degree does not need to have been obtained in a school in the United States, but you must be licensed to practice clinically within the United States.

I will conduct approximately 60 minute long interviews. You will be asked demographic questions at the beginning of the interview, and then asked a series of 11 questions that will focus on exploring your personal understanding of depression from your Korean cultural point of view, and how/if the understanding of depression in the Korean culture is different from the western perspective. You will also be asked about your personal clinical work and how you feel that your knowledge of depression from a Korean point of view, and a western point of view, influences your clinical practice. The interviews will be recorded. Only myself, my research advisor,, and a transcriber will have access to the interviews. The transcriber will sign a confidentiality pledge.

Because this interview will ask you to reflect upon your culture and upbringing there may be emotional discomfort attached to your reflections; I only ask that you share what you feel comfortable with. The benefits of participation is being a part of research that is working to further cultural competent clinical practice with Korean individuals. In addition, you may enjoy having the opportunity to reflect upon and discuss these issues. I will not be able to provide any compensation for your participation.

Your interview will remain confidential and only myself, my research advisor, and a professional transcriber will have access. My advisor and the transcriber will not have access until identifying information has been removed. The transcriber will sign a confidentiality pledge to confirm confidentiality. As participants you will be coded by a number, not your name. During the interview please do not use any names or identifying information about clients, self, or family. If this research is used in any publication or presentation, any identifying information will be disguised or will be removed and names will be replaced with pseudonyms. All interviews, transcriptions and audio, consent forms, and data collected will be kept in a secure location, a password safe file on my computer, for a period of three years in accordance with the federal guidelines. Consent forms will be locked in a file cabinet for the same amount of time. If the material is needed past the three year mark it will continue to be stored securely and will be destroyed once no longer needed.

Participation in this research is voluntary. You have the right to refuse to any of the interview questions. You have the right to withdrawal from this study at any point in the interview by asking me to stop the interview and communicating to me that you would like to halt your participation in this research. If you chose to stop your participation, any record of your participation will immediately be erased. You may call or email to withdrawal any time

before April 2nd; the write up for this study will be started at this date and data will not be able to be taken out.

If you have any questions that should arise please feel free to contact me through email at ----- , or by phone at ----- . If you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me or the Chair at Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNIATURE INDICATIES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATIN AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOU'RE PARTICIATION, AND YOUR RIGHTS AND THAT YOU TO PARTICIPATE IN THE STUDY.

Please keep a copy of this Informed Consent for your recods

Signature

Date

Shannon Yambasky

Date

Appendix E

Thesis Interview Questions

Demographic Questions

1. What professional discipline have you been licensed in?
2. age
3. Were you born in Korea? Are you first, second, or third generation Korean American?
4. What gender do you most identify with?
5. How many years have you been clinically practicing?

Interview Questions

6. How is depression defined in Korean culture?
7. What are symptoms of depression in Korea or according to the Korean culture?
8. Do you remember family discussions about depression, and/or family members who identified as depressed, or you would consider depressed given what you understand today? If yes how was this spoken about in your family?
9. According to Korean culture, what is presumed about someone who seeks help for depression?
10. Do you know how depression is assessed and treated in Korea? If you know, how would you describe it?
11. What do you personally believe about depression and depression symptoms?
12. Do you know about how the understanding of depression has changed over the years in Korea? If so, how has it changed?
13. Are there differences you perceive in American/western views of depression compared to the Korean cultural views of depression?

14. As a clinician in the US, what do you integrate from your Korean cultural understanding of depression into your practice?
15. What is your experience of treating Korean clients with depression?
16. What would you find most important for clinicians working with Korean clients to understand about Korean culture and depression to better service their client?
17. What do you think is the greatest need for further research in regards to Korean Americans and mental health utilization?