

A CASE STUDY OF AN ETHNICALLY-TAILORED COMMUNITY-BASED  
MENTAL HEALTH PROGRAM: WASHINGTON CHRISTIAN COUNSELING INSTITUTE

by

Gemma Imsook Sohn

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Liberty University

May 2016

A CASE STUDY OF AN ETHNICALLY-TAILORED COMMUNITY-BASED  
MENTAL HEALTH PROGRAM: WASHINGTON CHRISTIAN COUNSELING INSTITUTE

by Gemma Imsook Sohn © Copyright, 2016

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Liberty University, Lynchburg, VA

2016

APPROVED BY:

---

Lisa Sosin, Ph.D., Committee Chair

---

David Jenkins, Psy.D., Committee Member

---

Aubrey Statti, Ph.D., Committee Member

## ABSTRACT

Disparities in health and mental health service utilization among racial and ethnic groups in the U.S. are well documented, with many studies having identified accessibility to linguistically and culturally informed services as a key barrier to service utilization. Korean Americans in particular, being the most recent immigrant group of Asian Americans, reportedly suffer from higher rates of depression and anxiety than other Asian American groups. There is, however, some indication that Asian Americans do utilize ethnicity-specific programs at a higher rate than mainstream services when such services are made available to them. Therefore, this study seeks to investigate and explain the case of the Washington Christian Counseling Institute (WCCI), an organization that utilizes an innovative mental health service delivery approach to address the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. It is hoped that the study contributes to developing a model for meeting the mental health needs of immigrant communities of similar cultural backgrounds in the US. The method used for this study is an intrinsic descriptive case study that is historical and sociological in orientation, utilizing record reviews, observations, and in-depth interviews for data collection. The key findings of this case study rendered a set of guiding principles that can help to create and maintain a mental health service delivery for underserved ethnic minority communities, which is ethnically-tailored, community-centered, and faith-based and promotes multi-level collaboration and integration.



## **Dedication**

Dedicated to my family

In loving honor of my husband Hyung

And my two sons Nathan and Eric:

With each of your personal sacrifice, support and understanding

I have come thus far and this work has reached its finish line.

## **Acknowledgments**

With a profound gratitude for God's faithfulness, I submit this work. Along the path of my academic journey, I have been blessed by so many individuals who have supported me with encouragements, insights, and inspirations. They have challenged me to go beyond what I thought I was capable of, but rather to rely on what God was able to do with me, His power and faithfulness. There are too many to name each one, but I want to name a few as I close this chapter in my professional development.

First, I am directly indebted to the people of Washington Christian Counseling Institute. Starting from the founder of Grace Community Center, Dr. and Mrs. Tong Soo Park, and the co-laborers including Sunny Park and Jinse Kim, the Friends of WCCI, who are the backbone of the organization, have shown me the love of Christ and what it means to serve others with Christ's heart. Among them, those who availed themselves for interviews have touched my heart and brought me to tears as they bear the evidence of God's grace for hurting people through this ethnic community, faith-based, non-profit organization.

Second, I want to thank the amazing teachers of Liberty University I have been privileged to learn from. I have never met a group of such dedicated, God-loving teachers who give themselves selflessly to their students. I give special thanks to my dissertation chair Dr. Lisa Sosin and the committee members, Dr. David Jenkins and Dr. Aubrey Statti. I would not have come to this finish line without their unwavering support and encouragement.

Last but not least, I am deeply grateful for my family who have been there every step of the way. In particular, I can never thank God enough for my husband Hyung Sohn who has read every single paper I have written and listened countless hours to my passionate discussions about mental health. He did so with love and enthusiasm, compassion and with the pleasure of being

proud of me. I am so blessed to have his dedicated love and support. Also, I am grateful for my two young sons, Nathan and Eric, who have taught me many life lessons without even being aware of it. The lessons about what it means to be resilient and the importance of advocacy for the marginalized overlapped with the lessons I took away from studying the case of WCCI. I am truly blessed to have had the opportunity to work on this dissertation project and to have all those who supported me through the entire process.

## TABLE OF CONTENTS

Abstract .....	<b>Error! Bookmark not defined.</b>
Acknowledgments .....	vi
List of Tables .....	xv
List of Figures .....	xvi
 CHAPTER ONE: INTRODUCTION .....	 1
Background of the Problem .....	1
Mental Health Needs of Non-English Speaking Minorities .....	1
Organizational Structure of Grace Community Center .....	3
Program Structure of WCCI .....	5
People of WCCI (Focus Groups) .....	7
Purpose of the Study .....	9
Rationale for the Study .....	9
Research Questions .....	10
Situation to Researcher .....	11
Assumptions and Limitations of the Study .....	11
Definition of Terms .....	12
Significance of the Study .....	14



Theoretical and Conceptual Framework .....	15
Additional Considerations .....	16
Organization of the Remainder of the Study .....	17
Summary .....	18
 CHAPTER TWO: REVIEW OF THE LITERATURE .....	 20
Introduction .....	20
Purpose of the Literature Review .....	20
Steps to the Literature Review .....	21
Roadmap for the Literature Review .....	21
Mental Health Needs among Minority Immigrant Communities .....	22
Immigration and Mental Health .....	23
Help-seeking Behaviors and Referral Patterns among Ethnic Minorities .....	30
Disparities in and Barriers to Mental Health Services for Ethnic Minorities .....	33
Matching Client and Clinician in Language, Culture, and Cognitive Orientation .....	38
Mental Health Needs among Asian Americans .....	43
Foreign-Born Asian American Immigrants and Mental Health Issues .....	44
Perceptions and Attitudes toward Mental Health Issues among Asian Americans .....	46
Underutilization of Mental Health Services among Asian Americans .....	49
Mental Health Needs among Korean Americans .....	53

Korean Americans and Mental Health Service Needs.....	54
Mental Health Service Utilization and Perceptions and Attitudes toward Mental Health Issues among Korean Americans.....	56
Korean Americans and Help-seeking Behaviors for Mental Health Services .....	58
Korean Americans and Barriers to Accessing Mental Health Services.....	59
Faith-based Mental Health Services .....	64
The Role of Faith in the Korean American Immigrant Community.....	65
The Role of Local Korean American Immigrant Church .....	66
Community-based Mental Health Services .....	70
Models of Community Mental Health Service System .....	71
Community Adaptation of the Collaborative Care Model.....	76
Summary of Literature Review.....	79
Gap between Knowledge and Practice .....	80
 CHAPTER THREE: METHODS.....	 81
Research Design.....	81
Selection of Participants .....	82
Data Collection and Procedures.....	85
Interviews.....	86
Observations .....	87

Document Reviews .....	88
Data Analysis and Synthesis .....	90
Validity and Reliability .....	91
Validity .....	91
Reliability.....	92
Ethical Considerations and Limitations .....	93
Summary .....	94
 CHAPTER FOUR: RESULTS .....	 97
Introduction.....	97
Data Collection and Analysis Procedure .....	100
Data Collection .....	100
Data Analysis and Logic Model .....	100
Description of Grace Community Center (GCC) .....	103
Birth of the Organization .....	104
Organizational Vision and Mission .....	105
Evolution of the Organization.....	106
Structure of the Organization.....	107
Description of Washington Christian Counseling Center (WCCI).....	112
Birth and Evolution of WCCI.....	114

Vision and Mission of WCCI .....	115
Location and Facility .....	115
The Board.....	116
Staffing and Leadership Structure .....	116
Funding, Financial and Other Resources .....	117
Partnerships.....	118
WCCI Programs.....	120
Evolution of the Programs .....	120
Equipping and Training Programs .....	121
Counseling Services.....	123
Prevention Education Programs.....	125
Summary of Programs (Services) .....	126
WCCI Focus Groups.....	127
Friends of WCCI.....	128
WCCI Youth Council .....	131
WCCI Professional Forum.....	133
Summary of Programs (Focus Groups) .....	137
Operational Strategy: Collaboration and Integration.....	137
Collaboration.....	138
Integration .....	141

Special Programs and Projects (Grants) .....	142
People of WCCI.....	144
Description of Service Providers .....	145
Description of Service Recipients.....	146
Short-term Outcomes .....	147
Mid-term Outcomes .....	149
Long-term Outcomes .....	153
Summary of Data Analysis .....	155
Summary .....	156
 CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS .....	158
Introduction.....	158
Key Findings.....	159
Research Question Part I: Organization (Research Question #1) .....	159
Research Question Part II: Programs (Research Question #2, 3, & 4) .....	161
Research Question Part III: People - Service Providers and Recipients (Research Question #5 & #6).....	163
Research Question Part IV: Salient Constructs (Research Question #7).....	164
Conclusions.....	164
Implications.....	166

Limitations .....	171
Recommendations for Future Research .....	172
Summary .....	173

REFERENCES .....	176
------------------	-----

## Appendixes

APPENDIX A .....	185
APPENDIX B .....	187
APPENDIX C .....	188
APPENDIX D .....	189
APPENDIX E .....	190
APPENDIX F.....	191
APPENDIX G .....	192
APPENDIX H.....	193
APPENDIX I .....	194
APPENDIX J .....	195
APPENDIX K.....	196

## **List of Tables**

Table 1: Focus Groups of Washington Christian Counseling Institute .....	8
Table 2.1: Meta-Analyses for Immigration Experience and Mental Health .....	29
Table 2.2: Help-seeking Behaviors and Referral Patterns among Ethnic Minorities .....	32
Table 2.3: Mental Health Service Utilization by Racial/Ethnic Youths.....	34
Table 2.4: Disparities in and Barriers to Mental Health Services for Ethnic Minorities .....	36
Table 2.5: Matching Client and Clinician in Language, Culture, and Cognitive Orientation .....	42
Table 2.6: Asian Americans and mental illness perceptions and help-seeking behaviors .....	48
Table 2.7: Research Summary of Asian Americans and mental health services utilization .....	52
Table 2.8: Research Summary of Korean Americans and Mental Health .....	61
Table 2.9: Research Summary of Korean Americans and Faith .....	68
Table 2.10: Models of Community-Based Mental Health Systems.....	74
Table 2.11: Comparison between Community Mental Health Centers and Alternative Mental Health Clinics.....	78
Table 3.1: Selected Participants: Organizational Leadership.....	83
Table 3.2: Selected Participants: Program Service Providers .....	84
Table 3.3: Selected Interviewees: Program Service Recipients.....	84
Table 4.1: Summary of GCC Sub-system.....	111
Table 4.2: Summary of WCCI Programs (Services) .....	127
Table 4.3: Summary of WCCI Programs (Focus Groups).....	137
Table 5.1: Characteristics of Alternative Mental Health Services .....	170

## List of Figures

Figure 1.1: Grace Community Center Organizational Structure .....	3
Figure 1.2: Washington Christian Counseling Institute Program Structure.....	6
Figure 1.3: Washington Christian Counseling Institute Focus Groups.....	7
Figure 2.1: Literature Review Funnel .....	22
Figure 2.2: Literature Review Integration .....	22
Figure 2.3: Acculturation Model.....	24
Figure 2.4: Stages of migration and psychopathology.....	28
Figure 2.5: Mental Health Service Utilization by Racial/Ethnic Youths .....	35
Figure 2.6: U.S. Census Estimates.....	45
Figure 3.1: Selection of Participants .....	83
Figure 4.1: Methodological Triangulation in Data Collection.....	97
Figure 4.2: Data Triangulation in Data Analysis .....	98
Figure 4.3: Multiple Units of Analysis .....	99
Figure 4.4: Basic Logic Model .....	102
Figure 4.5: Logic Model (content detail).....	102
Figure 4.6: Organization as a case study .....	104
Figure 4.7: Basic Organizational Structure of GCC .....	107
Figure 4.8: Logic Model Applied on a Single Broad System Level (GCC).....	108
Figure 4.9: WCCI Logic Model Nested within GCC Logic Model .....	113
Figure 4.10: Logic Model Applied at the Sub-system Level (WCCI).....	113
Figure 4.11: GCC and WCCI.....	114
Figure 4.12: WCCI Programs .....	121



Figure 4.13: Face-to-Face Counseling Hours by Type of Therapies Provided .....	124
Figure 4.14: Face-to-Face Counseling Hours by Recipient Categories.....	125
Figure 4.15: WCCI Special Focus Groups .....	128
Figure 4.16: WCCI Professional Forum: Pathways of Impact .....	134
Figure 4.17: WCCI Professional Forum: Pathways of Contribution.....	136
Figure 4.18: Inter-organizational Collaboration (WCCI Professional Forum).....	139
Figure 4.19: Inter-organizational Collaboration (WCCI Youth Council) .....	140
Figure 4.20: Overview of Intra and Inter-organizational Collaboration.....	143
Figure 4.21: Logic Model of People’s Lived Experiences .....	145
Figure 4.22: Recursive Process of Logic Model.....	149
Figure 4.23: Logic Model of People’s Lived Experiences .....	155
Figure 5.1: Exportable Service Delivery Model .....	175

## **List of Abbreviations**

Asian American and Pacific Islanders (AAPI)

Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH)

Center for Linguistic and Cultural Competency in Health Care (CLCCHC)

Community-Based Participatory Research (CBPR)

Community Mental Health (CMH)

Culturally and Linguistically Appropriate Services (CLAS)

Disparity in Quality of Health Care (DHCQ)

Ethnic-Specific (ES)

Faith Community Service Center (FCSC)

Grace Community Center (GCC)

Health Maintenance Consortium (HMC)

Montgomery Cares Behavioral Health Program (MCBHP)

Network Orientation Scale (NOS)

Partners In Prevention Fund (PIPF)

Principal Investigators (PI)

Rehabilitative Support Education and Training (ReSET)

Suinn-Lew Asian Self-Identity Acculturation scale (SL-ASIA)

Washington Christian Counseling Institute (WCCI)

## **CHAPTER ONE: INTRODUCTION**

Highlighting the need for and the disparities in the availability and utilization of mental health services by non-English speaking minorities, this study examines the field of culturally-informed mental health programs, which is the foundation for Washington Christian Counseling Institute (WCCI), the case example of this dissertation. Describing the needs that launched the establishment of WCCI, this study details the organizational structure and services provided and explores how WCCI is meeting the needs of the Korean American community in the Washington, D.C. metropolitan area.

In this chapter, the origins of WCCI and the rationale for the study are presented. Then, the research questions, assumptions and limitations, as well as the significance of the study are then discussed. Finally, the theoretical framework and perspectives that undergird and facilitate the study are offered along with a special consideration of the Christian faith.

### **Background of the Problem**

In this section, the background of the problem is described including the mental health needs of non-English speaking minorities, the organization structure of Grace Community Center (GCC), the programs structure of Washington Christian Counseling Institute (WCCI), and the WCCI focus groups.

### **Mental Health Needs of Non-English Speaking Minorities**

Mental health problems of non-English speaking minorities are well documented (Ahn, 2013; Antoniadis, Mazza, & Brijnath, 2014; Bernstein, 2007; Bernstein, Chen, & Bang, 2013; Bhugra, 2004; Cheung, Leung, & Cheung, 2011; H. Choi, 2001; S. Choi, 2013; Connor, 2010;

Evans, Pierce, Li, Rawson, & Hser, 2012; Herrick & Brown, 1998; Hyun, 1995; Kaltman, Pauk, & Alter, 2011; Khawaja, McCarthy, Braddock, & Dunne, 2013; S. S. Kim, 2004). Some of the factors that make minorities vulnerable to mental health problems, especially in immigrant communities, include stresses of many losses they endure such as loss of familiar support system, cultural familiarity, language proficiency, and economic hardships they face in the process of re-establishment. Some may also have faced trauma prior to leaving their homeland (Kaltman et al., 2011).

Despite the seriousness of their mental health needs, non-English speaking minorities face various challenges in receiving mental health services (Bernstein et al., 2013; Kaltman et al., 2011; Mier et al., 2010). Such challenges include difficulties in receiving valid psychological assessment, therapist preferences for particular client characteristics, delays in receiving help, and high rates of premature termination (K. H. Lee, 2010; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

Regardless of the reasons for the disparities, the underutilization of mental health services by such populations is evident in various research findings (Barreto & Segal, 2005; Bernstein et al., 2013; S. Choi, 2013; Herrick & Brown, 1998; Kaltman et al., 2011; Leong & Lau, 2001; Matsuoka, Breaux, & Ryujin, 1997; Sue et al., 1991; Wong, 2006; Wu, Kviz, & Miller, 2009). Sue et al. (1991) report that Asian Americans and Hispanic Americans underutilize public mental health services, while African Americans and Native Americans over-utilize such services when compared to their respective populations. As an illustration, in Los Angeles County where the data for their study was obtained, 8.7% of the county's population was Asian American, but they constituted only 3.1% of the users of the county's mental health system. On the other hand, 12.8% of the county's population at large were African Americans, but they constituted 25.5% of

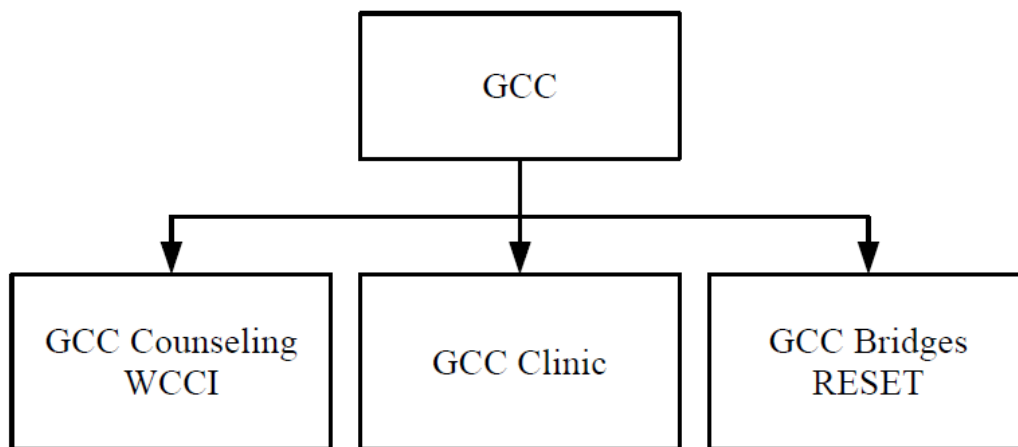
the mental health system's clientele. In addition, all ethnic minority groups have a higher dropout rate in their utilization of mental health services when compared to mainstream White American service recipients (Sue et al., 1991).

The ever increasing diversity within the U.S. population underscores the importance of a culturally sensitive paradigm for mental health care interventions targeting minorities.

According to the United States Census Bureau (2012) projection, minorities make up 37 % of the population and are projected to increase to 57% of the population by 2060. Specifically, the Asian American population is projected to more than double, from 15.9 million in 2012 to 34.4 million by 2060 (U.S. Census Bureau, 2012).

### **Organizational Structure of Grace Community Center**

Figure 1.1 shows the current organizational structure of Grace Community Center (GCC). As seen below, services provided under GCC include counseling related services (GCC Counseling/WCCI), free medical services (GCC Clinic), and other services (GCC Bridges/ReSET).



*Figure 1.1. Grace Community Center Organizational Structure*

GCC, initially called Faith Community Service Center (FCSC), became a charitable organization in 2003. Under FCSC, counseling related services were provided under the name of Potter's House. Potter's House later became WCCI. At the time of its formation in 2003, GCC elected to partner with Ephesians Ministry, which was a fairly large Christian counseling ministry that served the non-ethnic mainstream population in the Washington, D.C. metropolitan area at the time. Subsequently, for the following four years, during its partnership with Ephesians Ministry, Potter's House provided face-to-face, individual, and family counseling services by one licensed clinician who was also a staff member of Ephesians Ministry.

When GCC ended its partnership with Ephesians Ministry in 2008, Potter's House went dormant. However, in March 2009, the counseling services division of GCC was revived with the new name WCCI. Since then, WCCI has evolved into a vital organization for the community.

From its beginning, GCC as an organization has maintained its operations through interdependent collaborations with several local Korean American immigrant churches for its spiritual, financial, physical, and human resources. Therefore, the staffing and funding of GCC represent the organization's mission, which is to serve those in need in the local community by centralizing local Christian resources and making them available to all. The professional staff and volunteers are recruited from various area churches and funding is solicited in like manner (Kim, 2014).

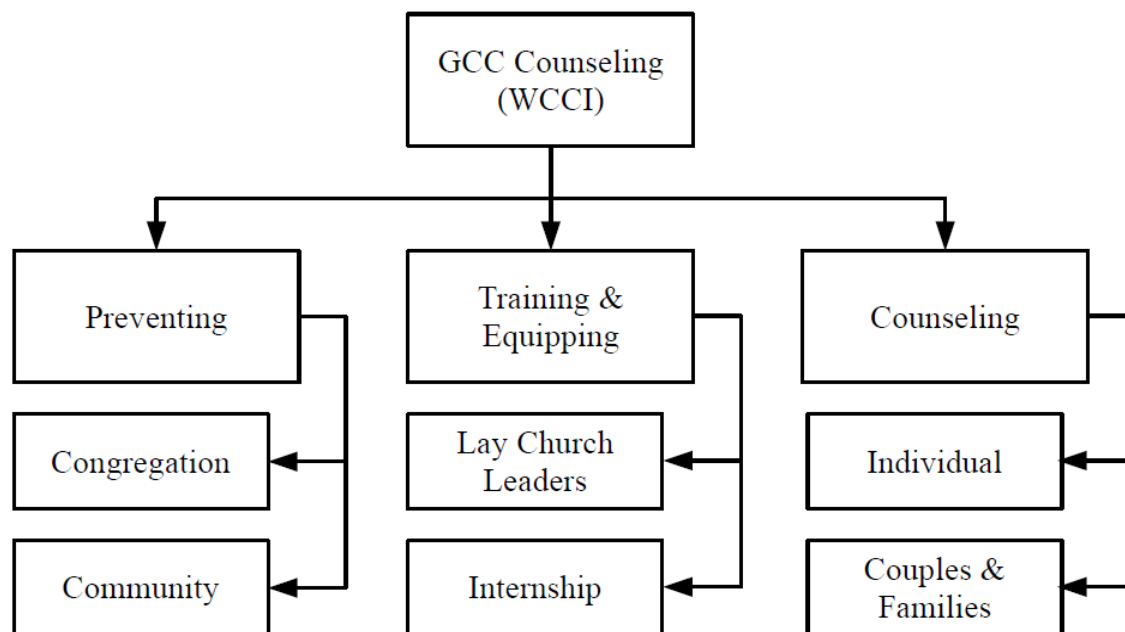
In addition to the counseling division (GCC Counseling/WCCI), there are two other divisions within GCC. The GCC Clinic provides free medical services and currently operates weekly on Sunday afternoons. It originated from one of the GCC founders and physician Dr. Tong Park offering his medical services after church service for congregation members who did

not have medical insurance and were in need of help. Currently, the free medical services are offered to the underserved in the area immigrant communities out of the GCC site by many volunteers including doctors, nurses, and pharmacists (GCC PowerPoint Presentation, 2014).

GCC Bridges, known as Rehabilitative Support Education and Training (ReSET) is a transitional and rehabilitative education and training program focused on women who have experienced catastrophic life events, such as divorce or death of a spouse. The ReSET program seeks to help women who need to rebuild their lives and rehabilitate their career qualifications. Through individual assessment of aptitude, qualifications, interests, ability and job/business opportunities, the ReSET program's goal is to guide, support, and assist the service recipients to gain relevant education and training necessary to put them on a path to improved financial independence, confidence, and social integration (GCC PowerPoint Presentation, 2014).

### **Program Structure of WCCI**

Figure 1.2 shows the program structure of WCCI. It presents three different areas of focus: (a) prevention related education, (b) training and equipping of counselors, (3) face-to-face counseling services.



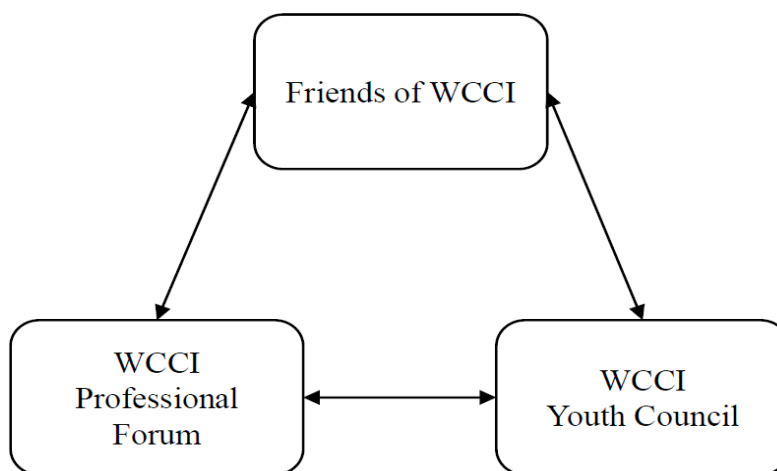
*Figure 1.2. Washington Christian Counseling Institute Program Structure*

Each of these areas includes programs that target different recipients. For prevention education, there are programs that target local Korean American church congregation members while other programs target the general public in the community. For training and equipping, there are programs that target non-professional local church lay leaders such as small group leaders and internship programs for Korean American students of various professional counseling education programs nearby. Finally, face-to-face counseling services are provided to individuals, couples, and families with children.

Remarkably, a model of a culturally informed, linguistically-compatible, community-based mental health program was being forged through the collaboration of many volunteers who were motivated by their Christian faith to serve others. Much of the work of WCCI naturally evolved, according to various needs that arose in each of its developing stages. Figure 1.3 introduces three focus groups within WCCI: Friends of WCCI, the WCCI Youth Council, and the



WCCI Professional Forum. Some details of each focus group are provided in Table 1 (GCC Board Meeting Minutes, 2014).



*Figure 1.3. Washington Christian Counseling Institute Focus Groups*

### **People of WCCI (Focus Groups)**

Friends of WCCI is a group of local church leaders in the Korean American immigrant community of Washington, D.C. that (a) have completed the training/equipping program of WCCI, and (b) have committed to support WCCI's effort to raise mental health awareness in the community. They organize yearly fund raising for WCCI and help with the activities of the WCCI Youth Council including the annual Family and Youth Mental Health Conference.

The WCCI Youth Council was formed following the first annual Family and Youth Mental Health Conference held in 2012. The WCCI Youth Council is comprised of several students, representing different high schools and different churches in the Washington, D.C. metropolitan area. They meet twice a month and participate in fellowship, and are educated on different mental health issues.

Finally, the WCCI Professional Forum provides a time and place where young Korean American Christian professionals in counseling related fields are invited to come, network, fellowship, and learn how best to integrate their faith with the work they do.

Table 1 below provides an overview of the different WCCI focus groups and each group's characteristics. It is worthwhile to look closely into this unique program of mental health related services to understand how WCCI has addressed the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area.

Table 1

*WCCI Focus Groups*

Group	Target population	Goal	Objectives
Friends of WCCI	Local Korean American church leaders (i.e. small group leaders)	Equip and train local church leaders to better serve his/her church congregation.	Monthly fellowship & meeting.
		Support and strengthen existing lay counseling/care ministries of local churches.	Bimonthly continuing education.
WCCI Professional Forum	Korean American counseling professional (i.e. school counselor, social worker, &)	Network among Korean American counseling professionals.	Quarterly fellowship & meeting.
		Promote volunteerism through learning and sharing the needs of Korean American immigrant community.	Quarterly professional enrichment training.
WCCI Youth Council	Local Korean American high school students	Raise mental health awareness among young people.	Biweekly fellowship.
		Foster the future leaders through equipping and training as it relates to mental health.	Biweekly mental health prevention education.
			Yearly youth & family mental health conference.

### **Purpose of the Study**

The purpose of this study is to investigate and explain how the services that WCCI offers address the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. In doing so, the study fulfills a larger purpose of providing a model that can be applied to many more immigrant communities in the U.S.

### **Rationale for the Study**

The issue of unmet or under-served mental health needs in the Korean American community has been presented in the introduction. The importance of meeting those needs by providing culturally informed and linguistically compatible services, tailored to the unique needs of the Korean American immigrant community, is the rationale for this present study.

To address the multiple needs of the Korean American community, WCCI has developed multiple programs. Therefore, a case of *programs* instead of a *program* is chosen for the present research. The reason is grounded in systems theory. Korean culture is highly system-oriented wherein the hierarchical structure and social network are important constructs of their worldview (S. C. Kim, 1985; Tata & Leong, 1994). Koreans, like members of many other Asian cultures, value collectivism over individualism, and thus value conformity and cooperation for a collective good (Tata & Leong, 1994). This is illustrated by the old Korean saying that “the nail that sticks up gets hammered down” which is in contrast to the Western proverb, “The squeaky wheel gets the grease.” Therefore, even WCCI, in its naturally evolved process of development, has sought collaboration and interdependence among its groups and programs (Kim, 2014). For example, one focus group, Friends of WCCI, sponsors fundraising events that support the activities of

another focus group, the WCCI Youth Council. In short, the theoretical construct of a system is naturally at work in and among the programs of WCCI.

The integrative approach of WCCI and its partners aligns with the literature review conducted. Focusing on the mental health needs of minority groups and the underutilization of services, the literature review supports the need for and effectiveness of culturally specific mental health services.

### **Research Questions**

The present research sought to answer the question “How are WCCI programs meeting the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area?” Based on Creswell’s guide to research questions (Creswell, 2013), the following detailed questions were pursued to answer the main research question stated above:

1. How does the organization function (including financing, staffing, and practicing)?
2. What programs are in existence?
3. What are the purposes and objectives of each program?
4. How are the programs formed, structured and operated?
5. Who is involved, including providers and recipients?
6. What are the responses of those involved?
7. What theoretical construct is helpful in understanding why the organization works or how it works?

A descriptive case study research design that is historical and sociological in orientation was employed (Hancock & Algozzine, 2011). It is an intrinsic case study in that the focus is on the uniqueness of the WCCI program in serving the particular ethnic community of Korean

American immigrants. To accomplish this, structured personal interviews were conducted. Also, historical documents and communications were reviewed and onsite observations were incorporated.

### **Situation to Researcher**

As a Korean American mental health clinician, the researcher is intimately familiar with the increasing needs for culturally sensitive and linguistically compatible mental health services. Being keenly aware of the cultural and language barriers to accessing or utilizing mental health services, the researcher has a vested interest in mental health programs and systems for the Korean American immigrant community. Believing in the possibility of ethnically-tailored, community-based mental health services that can meet the unique needs of language and culture, the case example of WCCI and its innovative approach has been chosen to address such needs. The researcher hopes to identify and extract factors and aspects of WCCI and its programs that can serve as a model for meeting the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. It is hoped that this study can become a basis for future proposals relating to local and federal policies and the seeking of funding that can support and facilitate the structure of similar mental health service delivery models such as WCCI.

### **Assumptions and Limitations of the Study**

There are several limitations to this case study. First, the study may be limited by the personal interest and predisposition of the researcher to the case. Personal interest may lead to the risk of being less than completely objective, resulting in an overly positive presentation of the

case, and possibly overlooking negative elements. These issues are addressed in Chapter Three. Second, the present case study may be limited by the participants for interviews and observations in that they are self-selected and are or have been voluntarily involved with WCCI. Therefore, they may also be biased positively toward the workings of WCCI. Finally, on a conceptual level, defining the mental health needs of Korean Americans is limited and cannot accurately and broadly cover the entire spectrum of the needs. Despite such limitations, in a general sense, it is believed that understanding the workings of WCCI can be hugely beneficial for communities with similar characteristics of the area and people that WCCI serves. Therefore, it is worthwhile to look closely into WCCI and its unique programs.

### **Definition of Terms**

The following terms are initially defined: Grace Community Center (GCC); Washington Christian Counseling Center (WCCI); Faith community Service Center (FCSC); and Rehabilitative Support Education and Training (RESET). Working definitions of the following terms are further clarified: minority ethnic group; Asian American; Korean Americans; culturally-sensitive/informed; ethnically-tailored; community-based, and faith-based.

1. Grace Community Center (GCC) is the parent organization formed to provide services to the Korean American community in the Washington, D.C. metropolitan area.
2. Washington Christian Counseling Center (WCCI) is a division of GCC and provides mental health services to the target population.
3. Faith Community Service Center (FCSC) is the name of the organization that later became GCC.
4. GCC Counseling is synonymous with WCCI.
5. Rehabilitative Support Education and Training (RESET) is the third service area that GCC offers in addition to the GCC Clinic and GCC Counseling.

The term *minority ethnic group* as it relates to the mental health needs presented in this study refers primarily to a foreign-born, non-English speaking ethnic minority group, such as Asians and Hispanics. However, on some occasions, when data relating to the utilization of mainstream mental health services by minorities are discussed, a US-born, English-speaking minority group, such as African Americans, is included.

*Asian American* in this study refers to Asian American and Pacific Islanders (AAPI), and refers primarily to those Americans of Chinese, Filipino, Indian, Vietnamese, Korean, or Japanese descent, according to the AAPI demographics of U.S. minority population growth (White House Initiative on Asian Americans and Pacific Islanders, 2010). Korean Americans in this study refers to foreign-born, first-generation Korean immigrants and their immediate families, who make up most of the Korean American population in the U.S. (Wu et al., 2009).

The term *culturally sensitive*, as it relates to a service delivery model of mental health care in this study, refers to a reflective practice approach based on a service provider's knowledge/awareness of the recipient's culture (Furler & Kokanovic, 2010; Moritsugu, Vera, Wong, & Duffy, 2014). The term is interchangeably used with similarly expressed terms *culturally informed* and *culturally competent*. The meaning of the term encapsulates many aspects including the attitudinal aspect of cultural appreciation, curiosity, and cognitive flexibility without preconceptions (Miu Ha, 2011). The term *ethnically-tailored* mental health service in the context of this study refers to the matching of service provider and recipient, so that they are of the same or similar ethnicity (Gamst, Dana, Der-Karabetian, & Kramer, 2004; Ziguras, Klimidis, Lewis, & Stuart, 2003). A linguistically-compatible service, which refers to matching the same language spoken in service provider and recipient, is one example of an ethnically-tailored service.

The term *community-based* or *community-centered* mental health service refers to services provided in a community setting that promote the well-being of individuals and the community of their locale. Community-based services are provided in collaboration of various organizations and systems within the local community (Moritsugu et al., 2014; Rosen, Gurr, Fanning, & Owen, 2012). The term *faith-based* mental health service refers to services provided in a faith context to promote the psychological well-being of individuals. Faith-based services are provided in integration of spirituality and psychology in its clinical content. For this study, the discussion of faith-based services focuses on the collaboration between faith-based communities (e.g., churches) and mental health service providers for the benefit of the service recipients (Patel, Frausto, Staunton, Souffront, & Derose, 2013).

### **Significance of the Study**

The significance of this study is twofold significance. First, this study offers WCCI a narrative account of its history in the making and the model resulting from extracting the elements that contribute to WCCI's unique and innovative approach to meeting the needs of the Korean American immigrant community. WCCI has evolved over the years to become what it is today. It is not a system of programs that were designed and implemented from the outset. Rather, with a group of compassionate people listening and following their hearts to minister to those in need, WCCI has been shaped to fit and fulfill the needs of the people. Therefore, this study can serve as an affirmation of the fruit produced by the labors of the many volunteers that have served with WCCI. This study also provides valuable feedback for the continual growth of the organization.



Second, this study provides a model to aid other immigrant communities of similar cultures in meeting the mental health needs of their people, especially for communities where the mainstream mental health services are significantly underutilized, due to language and cultural issues. The culturally sensitive, linguistically-compatible, faith-based, interdependent model of mental health services provided by WCCI can offer much insight for those who are interested in caring for the underserved ethnic communities around the US.

### **Theoretical and Conceptual Framework**

As mentioned earlier, this study is a qualitative, descriptive case study. As “the case” in this study is an organization and its programs, the theory that drives the description of the scope, depth, and parameter of the case is the systems theory (Germain, 1978; Kihlström, 2012). The application of systems concepts is evident in two different aspects of this case study. First, it is evident in the structure of WCCI and its larger context of GCC. Therefore, a systems perspective is useful for conceptualizing the interdependent features of different programs within WCCI as well as its collaboration with other external organizations such as local churches. GCC is a system providing health services that consists of interactive sub-systems, one of which is WCCI. The programs of WCCI are also interconnected by the collaboration of each program and its players.

Second, the systems approach is evident not only in the structure of WCCI, but also in the content of WCCI’s programs. Systems theory presupposes mutual feedback between a system and its environment (Germain, 1978; Kihlström, 2012; Michailakis & Schirmer, 2014). The programs of WCCI and GCC at large are driven by the unmet needs for culturally as well as linguistically compatible mental health services. The system perspective also provides a

conceptual theoretical framework for understanding problems as the results of interactions between a person and a larger system and environment, rather than believing that the problem resides only within the person (Kelley, 1994). Therefore, the Korean American immigrant community's mental health needs, which are deeply interconnected with their loss, grief, and the traumatic experiences of immigration and acculturation, can be understood through the systems theoretical grid.

### **Additional Considerations**

A consideration of the Christian faith as it relates to the mental health needs of the Korean American immigrant community is an important element in this case study. Choi-Kim (2009) suggests that the Korean American church is the most important institution in the Korean American immigrant community because it provides social and psychological, as well as religious, identity and fulfillment for its members. The Washington, D.C. metropolitan area, which is one of the major cities with a large number of Korean Americans, has seen Christianity growing among Korean Americans, many of whom had little to no Christian experience prior to living in the United States (S. G. Lee, 2009). S. G. Lee (2009) notes the growth of the number of Korean American churches, with the planting of “more than 4,329 Korean American evangelical churches in recent years” (p. 5).

The local Korean American immigrant church's support for and collaboration with WCCI is vital in its effort to provide the mental health services to the community. Much of the awareness for mental health needs and resources to meet those needs have been raised in conjunction with church support and encouragement for WCCI. Religious coping as means of dealing with the stresses of the acculturation process has been documented (Lyu, 2009). It is

pointed out that religious coping is intimately integrated into the personal lives of Korean American immigrants, as it offers coping resources through psychological, sociocultural, and spiritual support (R. Kim, 2006; Lyu, 2009). Connor (2010) also suggests that religious migrants have better mental health than the non-religious migrants, as religious devotion brings comfort to their emotional difficulties that they face during their cultural adjustment to a new society. The pattern of coping with difficulties or seeking help by Korean Americans indicates the importance of church leaders, namely Korean American pastors, in that most referrals are made by them for their congregation members (K. H. Lee, 2011). Faith and the support of church leaders play a significant role in achieving mental health in the WCCI model, and are elaborated upon throughout this study.

### **Organization of the Remainder of the Study**

This study is organized in five chapters. Chapter One introduces this study and includes the background, purpose, and rationale of the research along with the research question and the definitions of the terms used. The limitations of this study as well as the significance of the research are also presented. Chapter Two presents a literature review organized in different tiers. The first tier pertains to mental health issues of ethnic minorities in general, the second tier pertains to Asian Americans, and the third tier pertains to Korean Americans specifically. Chapter Three presents the methodology of the data collection and analysis. Chapter Four presents the data analysis and results. Finally, Chapter Five presents the conclusions of the study, including the findings, implications, and recommendations.

## Summary

Adjusting to a new life in the United States presents many stresses for immigrant minorities, as migration disrupts individual and family life cycles, and the many losses associated with such disruptions can be traumatic (Kelley, 1994). The stresses are especially acute for non-English speaking minorities such as Korean Americans, many of whom have immigrated within the past 30 years. The fact that such stresses manifest into mental health problems is well documented (Bernstein, 2007; Cheung et al., 2011; S. Choi, 2013; Park, 2012; Park & Bernstein, 2008; Shin, 2002; Wu et al., 2009). Unfortunately, while the needs are great, the immigrant community is often unable to take advantage of mainstream mental health services due to cultural and language difficulties. Moreover, practical suggestions and specific models which one could follow in order to overcome the aforementioned problems are lacking as well. Therefore, the development of culturally sensitive, linguistically compatible, community-based mental health services is critical for providing mental health services for the rapidly growing Korean American immigrant communities. In view of such needs, the case of WCCI and its programs may serve as a model.

The present study is a qualitative description of a culturally-informed, language-specific, community-based mental health service program, the Washington Christian Counseling Institute (WCCI), in the Washington, D.C. metropolitan area. The case here is WCCI and all its programs as well as the people involved. The context of WCCI is within its parent organization Grace Community Center (GCC). Therefore, a brief review of GCC and its various programs, including WCCI, as well as the relations between the various programs is provided. In this way, the innovative and collaborative workings of WCCI's programs within and with GCC can be understood within a larger context. The context in which WCCI programs are placed, including

its parent organization GCC, is described. The processes by which WCCI delivers mental health service and the interactions between programs, service providers, and recipients, is also described. In the next chapter, which presents a literature review, the unmet needs for mental health services of non-English speaking minorities, with particular emphasis on Korean Americans, is further described in depth.

## **CHAPTER TWO: REVIEW OF THE LITERATURE**

### **Introduction**

In this chapter, a review of literature is presented as it relates to immigrant minority communities and their mental health needs, with the underutilization of mental health services by Asian Americans immigrant communities being examined in particular. Furthermore, the literature review spotlights the particular seriousness of the mental health needs of Korean Americans, since their political and economic history and short immigration period is unique relative to other Asian Americans.

There exists a relatively limited number of empirical research studies specific to different ethnic minority immigrant groups and their mental health issues. Such limitations notwithstanding, this chapter consists of a review of several notable and relevant prior research studies in order to situate this research project in reference to previous empirical inquiry and to establish the importance of the present study.

### **Purpose of the Literature Review**

The purpose of this literature review is to delve into the existing body of information on mental health issues faced by ethnic minority immigrant populations in general and the Korean American population in particular, their needs in this area, and the services available to them. The review highlights the need for and relevance of the proposed study, which seeks to present an effective faith-based service delivery model that is both culturally-informed and community-centered.

### **Steps to the Literature Review**

The search for literature related to this inquiry entailed using the following key words: ethnic immigrant minorities and mental health, Asian American and mental health, Korean American and mental health, nonprofit health or mental health, faith-based or community-based mental health, religious coping, and faith and mental health. The search engines used were: PsycINFO, ProQuest, WorldCat, and Google Scholar, and other scholarly writings published between 1970 and the present. The review of the literature was conducted on studies focusing first on general and then the specific populations (from ethnic minority to Asian American to Korean American). Then the literature review focused on studies of faith-based mental health services and studies of community-centered mental health services.

### **Roadmap for the Literature Review**

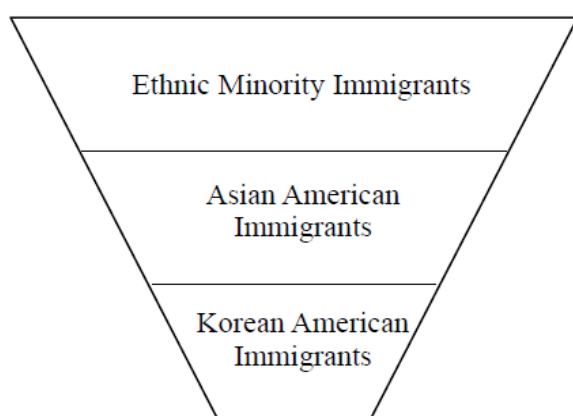
The literature review is laid out in the following manner: first, mental health issues among minority immigrant populations are discussed in general; second, mental health issues among Asian American minority immigrant populations are discussed; and third, mental health issues affecting the Korean American immigrant population are highlighted. The significance of faith-based mental health services to the Korean American community is also discussed. Finally, the available literature on community-centered mental health service delivery models of the past and present are reviewed against the backdrop of the mental health issues experienced among these minority immigrant groups, with a focus on Asian Americans and specifically on Korean Americans.

Due to the relative paucity of empirical literature available on effective mental health service delivery models for ethnic minority immigrant communities in general, let alone any specific population such as Korean Americans, general models of community-centered mental

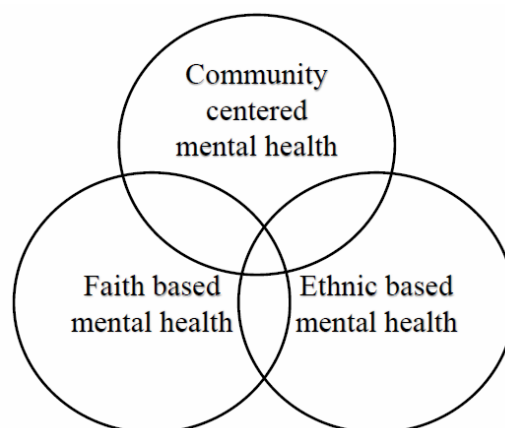
health programs are reviewed. The limited amount of literature available on the subject matter points to the critical need to identify and develop an effective mental health service delivery model that is sensitive to the language and culture of particular minority immigrant groups.

As this study explores faith-based models, religious coping as a method of dealing with mental health issues is examined in addition to the aforementioned analysis. Therefore, the relevance and importance of the faith community and its collaboration with community-based mental health service programs are emphasized through the review of the available literature.

Figures 2.1 and 2.2 describes the above roadmap.



*Figure 2.1.* Literature Review Funnel



*Figure 2.2.* Literature Review Integration

### **Mental Health Needs among Minority Immigrant Communities**

The effective delivery of mental health services to ethnic minorities has been historically lacking, yet minorities are at a high risk for psychological stresses and mental health problems (Akutsu, Snowden, & Organista, 1996; Kim & Duckson, 2007; Morgan & Hutchinson, 2010). In this section, the prevalence of and disparity in the occurrences of mental health issues and the need for an effective service delivery model for minority immigrant communities are discussed.



The specific impact of immigration on mental health interventions, matching clients with clinicians, help-seeking behaviors, and the referral patterns of ethnic minorities are highlighted, as are the barriers to the delivery of mental health services to ethnic minorities.

### **Immigration and Mental Health**

The process of immigration and acculturation can produce significant stresses. The impact of immigration on mental health is discussed in the following section. Morgan and Hutchinson (2010) found in their review of published studies that schizophrenia and other psychoses have a high rate of incidence among migrant populations. The authors' considerations of possible social determinants for the high rate of psychosis among migrant populations yielded partial evidence that exposure to various social adversities salient to one's life experience, such as immigration, can lead to a sensitized and thus vulnerable neurological state.

Citing a report by the Urban Institute on the well-being of young children of immigrants, Kim and Duckson (2007) forewarned mental health service providers to be aware of minority immigrant children who are more vulnerable to struggling with mental health problems and are more likely to do so than their mainstream counterparts. This forewarning is consistent with the aforementioned argument made by Morgan and Hutchinson (2010) that childhood disadvantages increase the likelihood of subsequent social adversities and can touch off a cascade of problems, including the risk of psychosis.

In a qualitative study exploring the life experiences of 19 young Korean American immigrants, S. S. Kim (2004) sought to develop a grounded theory for understanding the process of adaptation that young Korean American immigrants go through. The study participants were 19 young Korean American immigrants who came to the U.S. between the ages 9-16 and lived in the U.S. for 4 to 19 years at the time of the study. The study data included interviews, field

notes, analytic logs, and observations. Data collection and analysis were carried out concurrently. As a result, ten major conceptual categories were identified, as were ten patterns of actions related to “being in between”, meaning ways that the participants negotiate boundaries between a host of categories including between two cultures, two languages, two generations and between home and school environments (p. 521).

S. S. Kim (2004) posited that young Korean American immigrants engage in negotiating boundaries in social, cultural, and generational contexts in their adaptation processes. He identified several personal and structural factors that are salient in the adaptation process including acculturating into main stream society. As seen in Figure 2.3 below, S. S. Kim (2004) summarized the acculturation model by indicating that individuals adjust to lessen conflict by selecting one of four adaptation modes: integration, assimilation, separation, or marginalization. Separation refers to an individual’s acculturation into one’s own ethnic culture, while assimilation refers to acculturation into the dominant culture. Integration (or biculturalism) refers to an individual’s acculturation into both cultures, while marginalization refers to acculturation into neither of them.

	<i>Acculturate into one’s own ethnic culture</i>	<i>Not acculturate into one’s own ethnic culture</i>
<i>Acculturate into the dominant culture</i>	Integration (biculturalism)	Assimilation
<i>Not acculturate into the dominant culture</i>	Separation	Marginalization

Figure 2.3. Acculturation Model

S. S. Kim (2004) posited that young immigrants experience both intercultural and intergenerational conflict during the process of negotiating these boundaries: intercultural conflict between their culture of origin and that of mainstream society, and intergenerational conflict within the cultural familial system caused by the individual’s speed or degree of

assimilation into mainstream society. The number of participants in S. S. Kim's (2004) study is not large and may not be representative of the immigrant population as a whole, let alone the Korean immigrant population. Therefore, it is difficult to extrapolate these findings to the immigrant ethnic minority at large with any degree of confidence. Nonetheless, the findings are useful for putting forth a theoretical framework with which to understand the acculturation process and related mental health issues.

In a study by Jang, Roh, and Chiriboga (2014), the authors examined variances in the relationship between acculturation and depressive symptoms in two groups of older Korean Americans. One group ( $n = 670$ ) was from central Florida, an area with a relatively low density of Korean Americans), whereas the other group ( $n = 420$ ) was from New York City, an area with a relatively high density of such individuals. In particular, the study examined whether acculturation's impact on depressive symptoms would vary by geographical locations. The authors used hierarchical regression modeling in which the initial model tested the effect of acculturation on depressive symptoms. In the initial model, the authors found that in both groups, acculturation was a significant predictor of depressive symptoms; that is, lower levels of acculturation were associated with higher levels of depressive symptoms.

Based on this initial model, Jang et al. (2014) introduced control variables such as demographic (e.g. age, sex, marital status, and education), health-related (e.g. chronic conditions and functional disability), and psychosocial (social network, filial satisfaction, and a sense of mastery) factors in subsequent models. The authors found that the level of acculturation remained a significant predictor for the Florida group. However, for the New York City group, the introduction of control variables resulted in a decline in the correlation between acculturation and depressive symptoms. The authors thus suggested that persons living in areas with a high

density of individuals of the same ethnic background may benefit from the greater availability of ethnic-oriented resources.

Similarly, a review conducted by Phinney, Horenczyk, Liebkind, and Vedder (2001) on immigration, adaptation, and ethnic identity acknowledged the complexity of adaptation processes. Phinney et al. (2001) reviewed existing theory and literature on research regarding the interplay between ethnic and national identity and acculturation, with a focus on the relationships between ethnic identity and identification with the new society, the relationships between these identities and the adaption of immigrants, and how these relationships vary across group and national contexts. Citing Berry (1990, 1997), Phinney et al. classified the adaptation processes used by the immigrants described in their literature review into four acculturation strategies based on answers to two questions: (1) whether it is of value to retain one's ethnic identity of origin, and (2) whether it is of value to adopt the national identity of the new society. The four strategies were classified as integrated (retain strong ethnic identity and identify with the new society), assimilated (give up the ethnic identity, identify with the new society), separated (retain strong ethnic identity, not identify with the new society), and marginalized (identify with neither). The authors indicated that each of the four possible acculturation strategies may be dominant in some people and in some settings. They further indicated that integrated acculturation is associated with higher levels of overall well-being than other acculturation strategies, and suggested finding a balance between immigrants' cultural retention and adaptation to the new society.

Being a review of other studies (i.e. being an "analysis of analysis"), the quality of the findings and conclusions presented in Phinney et al. (2001) are difficult to ascertain. In addition, the review is not particular to any immigrant group or to any immigrant-receiving country. Thus,

the applicability to any particular immigrant group (e.g. Korean American immigrants) within a particular country (e.g. the US) may be limited. Nonetheless, the concept of the adaptation processes and accompanying acculturation strategies provide a useful framework for understanding immigration and its impact on mental health among minority populations such as Korean Americans.

Similar to the review of published studies performed by Morgan and Hutchinson (2010), Bhugra (2004) conducted a review of studies with regard to the migration experience and incidences of mental illness among ethnic minorities. Bhugra searched publications using MEDLINE and other databases (118 references total) and selected publications for review based on their relevance to migration and stressors related to migration among ethnic minorities. Three areas of focus were investigated – schizophrenia, common mental disorders (e.g. depression and anxiety), and post-traumatic stress disorder.

Bhugra (2004) reviewed the different stages of migration (premigration, migration, postmigration, and acculturation) and their related stresses. As a result, the likely psychopathological phenomenon for each stage was identified as well as the psychological vulnerabilities and resiliencies. The review resulted in the hypothetical model of migration and psychiatric disorders shown below in Figure 2.4. Bhugra concluded that migration is a complex process and that the role of various social and cultural factors such as the nature of the immigration (i.e. forced or voluntary), individual resilience factors, and different generational migrant viewpoints must be considered.

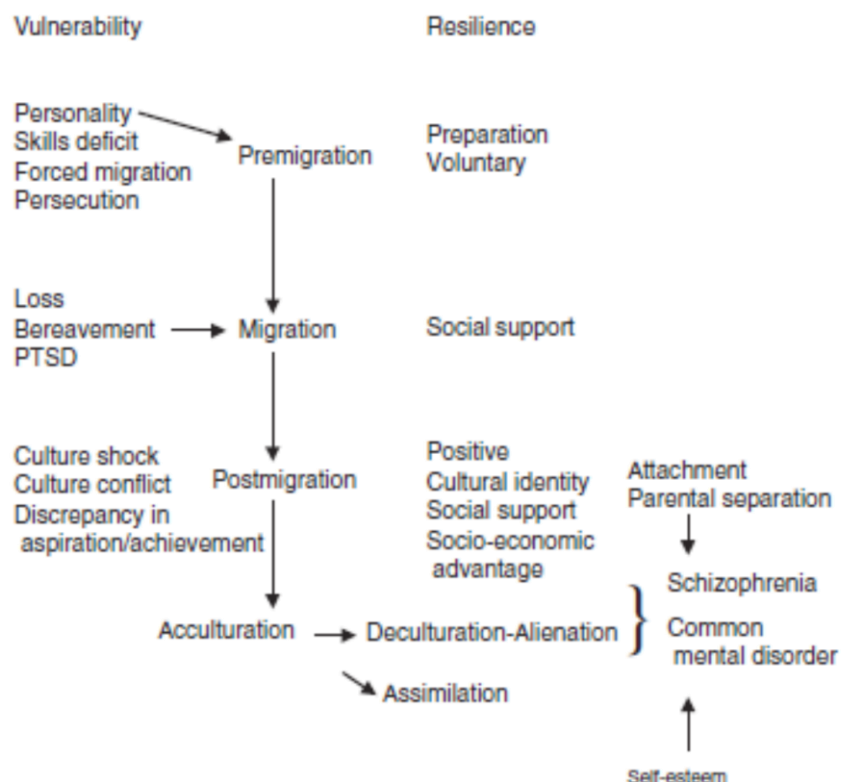


Figure 2.4. Stages of migration and psychopathology: A Hypothetical Model of Migration and Psychiatric Disorders. Adapted from “Migration and Mental Health,” by D. Bhugra, 2004, *Acta Psychiatrica, Scandinavica*, 109(4), p. 245. Copyright 2004 by Blackwell Munksgaard. Adapted with permission.

Other than mentioning the findings of some of the individual studies reviewed, Bhugra (2004) provides little to no details regarding the studies. For example, Bhugra does not provide much detail as to the methodologies used in the studies reviewed. Since little is known regarding how rigorous each study was, the applicability of the individual findings may be questionable without a review of the studies themselves. Nevertheless, the sheer number of studies (118 references listed) may lend some credibility to the overall conclusions reached by Bhugra.

As shown in the summary of immigration experience and mental health seen in Table 2.1 below, the meta-analyses for immigration experience and mental health, it is evident that migration can induce significant stresses and that further study can offer answers to the etiology

and management of mental illness among immigrant populations (Bhugra, 2004). Identifying an effective service delivery model to meet the needs of minority immigrant communities is particularly important and is the purpose of this present study.

Table 2.1

*Summary of Immigration Experience and Mental Health*

Author(s)	Research Focus	Method	Findings
Morgan, & Hutchinson (2010)	Examine social determinants of psychosis in migrant and ethnic minority population in UK.	Review of published studies.	Schizophrenia and other psychoses high among migrant population  Exposure to social adversity in the process of acculturation associated with high rates of psychiatric crisis
Phinney, Horenczyk, Liebkind, & Vedder (2001)	Examine relationship between new society and ethnic identity/identification – variation in relationship across groups in national contexts.	Review of current theory and research regarding ethnic identity, immigration, and the implications of ethnic identity for the adaptation of immigrants.	Issues surrounding ethnic identity, immigration, and adaptation are complex  Most immigrants prefer “integration” – retain culture of origin while adapting to new culture  Integrated identity associated with higher levels overall well-being
Bhugra (2004)	Examine information on how migration influences mental state of individuals	Review of published studies.	Migration can induce significant stress, but individual differences need to be considered (e.g. coping strategies, resilience of different individuals)
Jang, Roh, & Chiriboga (2014)	Examine how the impact of acculturation on depressive symptoms varies between two groups of older Korean Americans in different geographic locations.	Quantitative – hierarchical models and regression analysis  Participants – first group central Florida residents (low density of Korean Americans), (N = 672); second group New York City residents (high density of Korean Americans (N = 420)	Acculturation level found to be a significant predictor of depressive symptoms for both groups  Acculturation level remains a significant predictor of depressive symptoms for Florida (low density) group even after allowing for control variables (demographic, health-related, and psychosocial)  Acculturation level declines in significance as a predictor of depressive symptoms with the introduction of control variables

### **Help-seeking Behaviors and Referral Patterns among Ethnic Minorities**

There does appear to be an important difference among ethnic minorities in help-seeking behaviors and referral patterns (Akutsu et al., 1996; Yeh et al., 2002), which would need to be taken into consideration for delivering effective mental health services. To the extent that services are geared toward a particular minority population, it is important to effectively communicate the availability and relevance of available services to the targeted population. To that end, Akutsu et al. (1996) examined the help-seeking behaviors and referral patterns of several different ethnic minorities in a public mental health system. This study utilized an adult (age 18 years and older) sample population of 1,095 African Americans, 2,168 Asian Americans, 1,385 Hispanic Americans, and 2,273 White Americans and queried about their participation in ethnic-specific versus mainstream programs. Through intake forms and follow-up interviews, demographic, financial, and clinical information, covering over 300 categories of referral sources, were identified and organized into six broad categories: (a) self-referrals, (b) referrals by families/friends, (c) referrals from criminal justice programs, (d) referrals from social service programs, (e) referrals from hospitals/clinics, and (f) referrals from mental health programs/practitioners.

Akutsu et al. (1996) yielded a number of findings. First, ethnic minorities were more likely than White Americans to have been referred by natural help-giving and lay referral sources (e.g., families, friends, health and social services) in both ethnic-specific and mainstream programs. Second, for Asian and Hispanic Americans, clients in ethnic-specific programs were more likely than clients in mainstream programs to have been referred by natural help-giving and lay referral sources. Interestingly, for African Americans, clients in ethnic-specific programs



were more likely to have been self-referred than clients in mainstream programs. This could be because language generally is not an issue for African Americans.

The results from Akutsu et al. (1996) show that there were significant differences in the help-seeking behaviors and referral patterns of ethnic minority populations in ethnic-specific programs in contrast to mainstream programs. Non-English speaking clients were more likely to have sought ethnic-specific programs for obvious reasons. However, even after controlling for language preference, the help-seeking behaviors and referral patterns were persistent. Akutsu et al. concluded that it is important to consider ethnic-specific programs. The U.S is becoming more heterogeneous in its cultural and ethnic diversity, meaning that mental health systems must reconsider their clinical services and programs to better serve the special needs of different ethnic populations.

One strength of Akutsu et al. (1996)'s study is the number of participants involved. This allows the study results, in and of themselves, to be accepted with a significant degree of confidence. In view of the study results, it may be said that outreach efforts to minority populations should focus on natural help-giving and lay referral sources. It may also be said that concurrent efforts should be made to establish more culturally relevant and appropriate programs such as ethnic-specific community mental health programs.

In Akutsu et al. (1996), the authors themselves identified the short-comings of their study. They indicated that although ethnic-specific programs may promote increased service utilization and may be effective in service delivery to ethnic minority communities, whether or not ethnic-specific programs are more effective than other programs cannot be determined without further empirical research. According to the authors, such research to ascertain the significance of the contribution by ethnic-specific programs may need to include study of areas such as financing,

staffing, and treatment strategies employed by different organizations. Nonetheless, the differences in help-seeking behaviors and referral patterns among minorities, as shown in Table 2.2 below, should be carefully considered in order to better serve the special needs of different ethnic populations.

Table 2.2

*Research Summary of Help Seeking Behaviors and Referral Patterns among Ethnic Minorities*

Author(s)	Research Focus	Methodology	Findings
Akutsu, Snowden, & Organista (1996)	Examine the referral patterns to determine whether group differences in help-seeking and referral patterns are related to participation in ethnic-specific v. mainstream programs	Quantitative - Chi-square tests – alpha level of .05  Random selection of sample population (four types of clients): African Americans (N = 1095), Asian Americans (N = 2168), Hispanic Americans (N = 1385), and White Americans (N = 2273)  Treatments (two types of services): ES (ethnic-specific) and MS (mainstream) programs	Ethnic minorities more likely than White Americans to have been referred by natural help-giving and lay referral sources in both mainstream and ethnic-specific programs  For Asian and Hispanic Americans, clients in ethnic-specific programs more likely than clients in mainstream programs to have been referred by natural help-giving and lay referral sources  For African Americans, clients in ethnic-specific programs more likely than clients in mainstream programs to have been self-referred
Yeh et al. (2002)	Investigate differences in referral sources, primary diagnoses, and service types for three racial/ethnic groups (African Americans, Asian/Pacific Islander Americans, and Hispanic Americans) as compared to non-Hispanic White Americans	Quantitative - logistic regression model to examine relationship between (D) referral sources, primary diagnoses, and service types, and (I) race/ethnicity, age, gender, and DSM-IV GAF scores  Participants: children and adolescents who received outpatient mental health services (N = 3962)	Significant differences exist in referral, diagnosis, and services received for youth from racial/ethnic minorities when compared with non-Hispanic White American youth  African Americans more likely to be referred from juvenile justice and child welfare; less likely to be referred from schools.  Asian/Pacific Islander Americans more likely to be referred from child welfare; less likely to receive services from schools  Hispanic Americans more likely to be self-referred or referred by family members; less likely to be referred from schools or mental health agencies

The studies noted above indicate that the help-seeking behaviors and referral patterns of ethnic minority populations are different from those of White Americans, and even different from each other. Thus, it would be beneficial to consider providing ethnic-specific programs. To effectively provide such programs, it would also be beneficial to understand what barriers exist to receiving services for ethnic minority population.

### **Disparities in and Barriers to Mental Health Services for Ethnic Minorities**

Disparities in the utilization of health and mental health services for ethnic minorities are well documented (Garland et al., 2005; Laraque & Szilagyi, 2009; S. Lee et al., 2009; S. Lee et al., 2011; Le Meyer, Zane, Cho, & Takeuchi, 2009; Leong & Lau, 2001; Lin, 2011; Lo, Cheng, & Howell, 2014; Miranda, Lawson, & Escobar, 2002; Zane, Hatanaka, Park, & Akutsu, 1994). For example, one study by Garland et al. (2005) indicated that there are significant racial/ethnic disparities in the utilization of mental health services among high-risk youths ages 6 to 18. Their study randomly selected youths ( $N = 1256$ ) who received services from a large, publicly funded program offering social, legal, educational, substance abuse, and mental health treatment services and programs. Youths and caregivers were interviewed and assessed in the areas of mental health service utilization, psychiatric diagnoses, functional impairment, caregiver strain, and parental depression using various established instruments such as Service Assessment for Children and Adolescents, the NIMH Diagnostic Interview Schedule, and the Children's Global Assessment Scale. After controlling for the effects of potentially confounding variables, such as family income and functional impairment, significant racial/ethnic group differences were found regarding the likelihood of receiving any mental health service (see Table 2.3 and Figure 2.5). Although race/ethnicity did not exert a significant effect on the use of informal or 24-hour care

services, a significant difference can be seen among the groups' utilization of formal outpatient services.

Table 2.3

*Mental Health Service Utilization by Youths Age 6-18 Years in a Large, Publically Funded System of Care by Racial/Ethnic Group*

Service	Weighted Percent				Analysis			
	Non-Hispanic White (N=554)	Latino American (N=332)	African American (N=282)	Asian American/ Pacific Islander (N=88)	$\chi^2$	df	Design-Based F	p
Outpatient services								
Specialty mental health services <sup>b</sup>	67.6	53.4	51.8	32.8	60.6	3	11.4	<0.001
Other nonspecialty services <sup>c</sup>	20.2	15.6	16.5	19.6	4.6	3	0.97	0.40
Alcohol and drug abuse treatment services	5.4	3.7	1.2	11.3	22.1	3	6.7	<0.001
Any outpatient service	73.5	60.3	57.1	51.5	43.0	3	7.8	<0.001
24-hour-care services								
Inpatient psychiatric hospital or inpatient psychiatric unit services	6.5	4.6	2.2	3.6	10.1	3	3.7	<0.02
Residential treatment center or group home services	7.4	5.9	7.4	1.9	4.9	3	1.0	0.38
Alcohol or drug abuse treatment <sup>d</sup>	3.5	4.4	1.2	2.0	7.3	3	1.2	0.30
Any 24-hour-care service	14.4	14.0	10.2	6.8	7.3	3	1.5	0.23
Informal services								
Self-help groups, peer counseling	17.5	18.5	7.4	16.7	23.1	3	3.7	<0.02
Counseling from clergy	4.1	5.7	4.4	8.6	4.7	3	1.0	0.39
Alternative healer	1.0	1.9	0.0	1.0	2.7	2	1.7	0.19
Any informal service	20.3	23.5	11.4	21.2	20.1	3	3.5	<0.02
Any mental health service <sup>e</sup>	79.0	70.1	63.7	59.3	37.1	3	6.7	<0.001

<sup>a</sup> Youths were identified from the active services rolls of one or more of five San Diego County public sectors of care (alcohol and drug abuse services, child welfare services, juvenile justice services, mental health services, and public school special education services for youths with serious emotional disturbance) during the first half of 1997.

<sup>b</sup> Includes visits to professional psychologists, counselors, community mental health clinics, and partial hospitalization or day treatment programs.

<sup>c</sup> Includes visits to pediatricians and physicians and in-home therapy or emergency room visits for emotional or behavioral reasons.

<sup>d</sup> Includes treatment in an inpatient setting or residential treatment center for substance abuse problems.

<sup>e</sup> Includes all outpatient, 24-hour-care, and informal service types listed in the table.

*Note.* Adapted from “Racial and ethnic differences in utilization of mental health services among high-risk youths,” A. F. Garland et al., 2005, *The American Journal of Psychiatry*, 162(7), p. 1339.

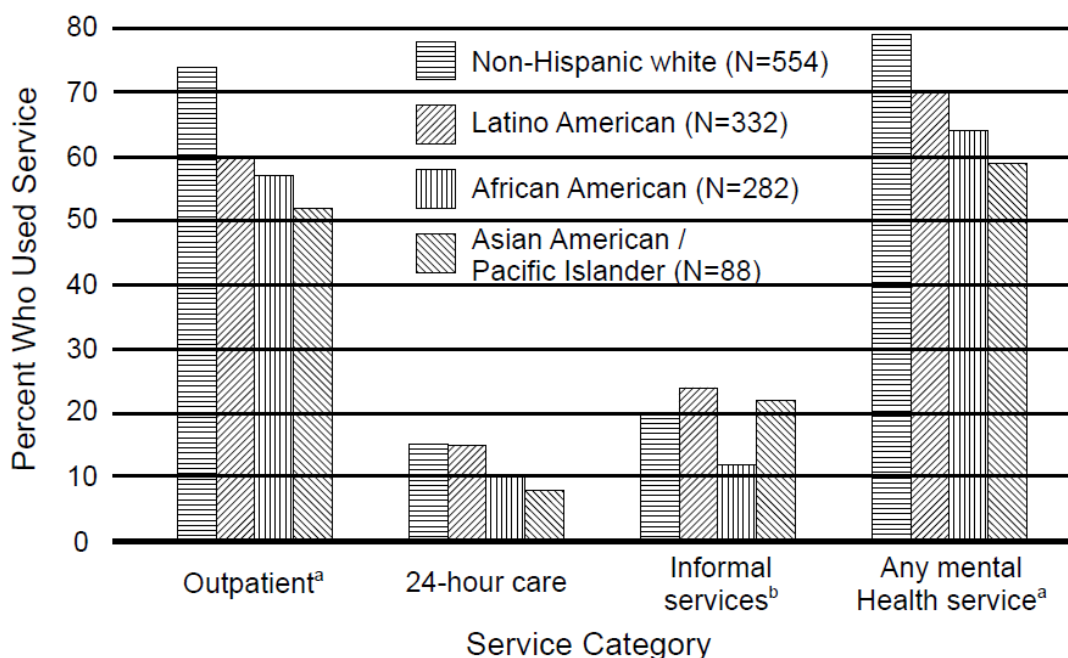


Figure 2.5. Adapted from “Racial and ethnic differences in utilization of mental health Services Among high-risk youths,” A. F. Garland et al., 2005, *The American Journal of Psychiatry*, 162(7), p. 1338.

Laraque and Szilagyi (2009), acknowledging the general phenomena of the impact of a therapeutic alliance on a successful outcome for mental health treatment, further noted that the therapeutic alliance includes access to and the availability of the clinician, which the current mental health system fails to provide for at-risk children and youth in different minority communities. The authors reviewed a number of articles about disparities in mental health utilization along racial/ethnic lines, including a study conducted by Coker et al. (2009) which examined racial/ethnic differences in mental health care utilization in fifth grade children. The researchers in the Coker study applied multivariate logistic regression analysis to cross-sectional data gathered from 5,147 fifth graders and their parents in three U.S. metropolitan areas; their study revealed a significantly lower utilization of mental health services among African American and Hispanic American children as compared to White Americans. However, the study also revealed that the disparity disappears especially for Hispanic American children when

covariates, including English proficiency, are accounted for. While it may not be determinative, the study results suggest that communication has an important effect on levels of mental health services utilization.

Based on their review of the articles, Laraque and Szilagyi (2009) also suggested that a lack of trust toward the health care system, the stigma associated with mental health issues, patient-doctor race concordance, and a participatory style of treatment may be associated with a lower utilization rate. This may suggest that accessibility to linguistically and culturally sensitive mental health services is of significant importance for immigrant minority populations.

As aforementioned, the racial/ethnic disparities in mental health service utilization are significant, especially for immigrant minority populations. Table 2.4 lists some of the barriers faced by immigrants in utilizing mental health services. As seen, the barriers include but are not limited to accessibility to linguistically and culturally sensitive services, as well as the stigma associated with receiving mental health services.

Table 2.4

*Research Summary of Disparities in and Barriers to Mental Health Services for Ethnic Minorities*

Author	Research Focus	Methodology	Findings
Garland et al. (2005)	Examine racial/ethnic disparities in the utilization of mental health services among high-risk youths	Quantitative study of randomly selected youths (N = 1256, age 6 to 18) who received services in a large publically funded system of care  Youths and caregivers interviewed with established measures of mental health service use, psychiatric diagnoses, functional impairment, caregiver strain, and parental depression	Considerable racial/ethnic group differences in accessing professional mental health services noted after potential confounding variables were controlled for  Race/ethnicity did not show significant effect on the use of informal or 24-hour care services

Laraque & Szilagyi (2009)	Examine disparities in utilization of mental health services for children of different sociodemographic groups.	Meta-analysis - Review of literature (21 references)	<p>Lower use among African American and Hispanic American children as compared to White Americans; however, disparity disappears for Hispanic American children when covariates are accounted for including English proficiency, suggesting that communication ability is important</p> <p>Stigma may be associated with lower use rate</p>
Coker et al. (2009)	Examine disparities in mental health services utilization along racial/ethnic lines among 5 <sup>th</sup> grade children.	Quantitative – Participants from public schools in three major U.S. metropolitan areas (Birmingham, Los Angeles, and Houston)	<p>Significant differences in parent-reported symptoms of ADHD, ODD, and CD across race/ethnicity: Hispanic American children less likely than White Americans to have symptoms, African American children more likely</p> <p>Significant differences in utilization among children with symptoms of ADHD, ODD, and CD across race/ethnicity: White American children with ADHD more likely to have used mental health care than African Americans and Hispanic Americans; similar results for children with OCD and CD</p>
Lo, Cheng, & Howell(2014)	<p>Examine race differences in prevalence rates of serious mental illness</p> <p>Examine race's role in relationships among such illness and variables of (a) social status and (b) health services</p>	Quantitative – Multivariate regression technique used to explain serious mental illness outcome indicators; <i>t</i> tests to compare African American and White American subsamples	<p>Level of reported chronic mental illness (in the past 30 days) among non-Hispanic African Americans exceeds that of non-Hispanic White Americans</p> <p>Indications that variables describing respondents' mental health care, along with their age and alcohol consumption, affect serious mental illness differently among African Americans compared to White Americans</p>
Miranda, Lawson, & Escobar(2002)	Examine barriers to reducing burden of affective disorders for ethnic minorities	Meta-analysis – review of existing literature	<p>Ethnic minorities less likely than White Americans to receive care for mood disorders</p> <p>Despite the similar rate of mental health issues of ethnic minorities when compared to White Americans, there are barriers for them in accessing appropriate care</p> <p>With the goal of eliminating such barriers, intervention research specific for serving minority groups is needed</p>
Le Meyer, Zane, Cho, & Takeuchi (2009)	Examine specialty mental health services utilization by Asian Americans with psychiatric disorders	Quantitative – Secondary analysis of data from the National Latino and Asian American Study (NLAAS) of 2002-2003; conduct logistic regression for U.S.-born and immigrant participants	<p>Significant underutilization of mental health services for Asian Americans in general</p> <p>More acute underutilization noted among Asian American immigrants</p> <p>Utilization by U.S.-born individuals almost twice that of immigrant Asian Americans</p> <p>Implications: need for 1) community education and 2) outreach efforts with a focus on networks and referral bridges with alternative health care providers</p>

### **Matching Client and Clinician in Language, Culture, and Cognitive Orientation**

As mentioned in the previous section, views toward mental health problems within the culture, language proficiency, and one's under-insured status are some of the factors recognized by researchers as contributing to disparities in mental health service utilization by ethnic minorities (Bernstein et al., 2013; Kaltman et al., 2011; Laraque & Szilagyi, 2009; K. H. Lee, 2010; S. Lee et al., 2011; Mier et al., 2010). However, the Akutsu et al. (1996) study mentioned above suggested that institutional barriers such as a lack of bicultural and bilingual staff at mental health facilities may be more significant contributing factors. These researchers found that ethnic-specific (ES) programs that give consideration to such barriers have been developed, and that service utilization increased in several instances after the implementation of such ES programs for Asian, Hispanic, and African American populations. Unfortunately, very little is known about the referral process by which ethnic minority clients are directed to seek such ES programs. Consequently, Akutsu et al. (1996) conducted a study to identify group differences in help-seeking and referral patterns in the public mental health system for African, Asian, Hispanic, and White American adults. The study also examined whether group differences were related to participation in the ES versus mainstream programs.

The results of Akutsu et al. (1996) indicated that (a) ethnic minorities were more likely than White Americans to have been referred by natural help-giving and lay sources (e.g. family, friends, health services, and social services) for both ES and mainstream programs, and that (b) Asian and Hispanic Americans in the ES programs were more likely than the same ethnic minorities in mainstream programs to have been referred by natural help-giving and lay referral sources. These findings suggest that targeting outreach efforts to natural help-giving and lay



referral sources as well as community-based programs in the respective ethnic minority communities may facilitate service utilization by ethnic minority groups.

Akutsu et al.'s (1996) findings are consistent with the results regarding the ethnic matching of clients and clinicians in studies of mental health service utilization by ethnic minorities (Sue et al., 1991; Takeuchi, Mokuau, & Chun, 1992; Ziguras et al., 2003), the results of which suggest that the ES programs can lead to increased service utilization. These studies are not without their limitations. For example, the study by Ziguras et al. (2003) took place in Australia, not the US, and the sample population was not randomly assigned to service providers. Nonetheless, they found that client-clinician ethnicity matching is an effective practice, producing a higher rate of client-initiated contact with service providers, lower rates of contacts with crisis intervention services, and the reduced frequency and duration of hospitalization. In general, the findings of the above studies suggest that mental health programs that are culturally sensitive and linguistically compatible achieve improved service utilization.

Lin (2011) studied premature termination of therapy in relation to client characteristics, service utilization patterns, and clinical outcomes. The study quantitatively analyzed data spanning 1988-1995 regarding Asian-oriented treatment programs that employed ES and culturally sensitive aspects in Northern California. Participants in the programs included clients ( $N = 843$ , 60.4% female, 39.6% male) of various Asian American subgroups (Korean, Japanese, Chinese, Vietnamese, Cambodian, Tagalog Laotian, and Mien) ranging in age from 3 to 90 years old. The findings indicated that being culturally specific and having a client-therapist match in terms of ethnicity and language correlated with frequency of premature dropout. According to the study, a client-therapist match in ethnicity ( $\chi^2 = 195.5$ ,  $p < .001$ ) and language ( $\chi^2 = 112.1$ ,  $p < .001$ ) decreased the level of premature termination among clients. This supports

the idea that culturally competent, ES treatment strategies improve service utilization and the effectiveness of mental health services.

A qualitative case study by Mier et al. (2010) examined interventions tailored for minorities as addressed by the Health Maintenance Consortium (HMC). The data for the study was collected in two phases. In the first phase, a questionnaire was administered to the HMC principal investigators (PI) involved in behavioral research projects on long-term maintenance of behavior change to achieve sustainable health promotion and disease prevention, with 17 out of the 21 PIs having responded. In the second phase, four of the HMC PIs were subsequently interviewed via telephone to follow up on issues related to cultural sensitivity and ethnic minorities. The study revealed several key considerations for a culturally sensitive paradigm in tailoring interventions for minorities, including (a) formative research, (b) individual adaptation, and (c) components that are congruent with the participants' demographics, cultural norms, and social context. Demographics can include ethnicity, language, and age. Social context may include socioeconomic status, social support needs, and gender bias. For the study, the authors included several references regarding a cultural sensitivity paradigm. This considerable amount of research led them to indicate that the contention that addressing the individual needs and sociocultural context of ethnic minorities in behavioral interventions does result in statistically significant health-outcome modifications among the participants (Mier et al., 2010).

The descriptive and the qualitative nature of Mier et al. (2010)'s study limits the applicability of its findings to treatment of general ethnic minority groups. However, the study is instructive in the potential effectiveness of tailoring interventions to a targeted population including immigrant ethnic minorities. The study indicated that cultural tailoring requires services to be ethnicity and language-specific, making them time consuming to develop. While

it is recognized that the effort may be resource intensive, culturally sensitive paradigms are recommended to help reduce mental health disparities between minorities and the mainstream population.

The factors that act as barriers to accessing mental health services – the need for culturally appropriate and linguistically compatible approaches for the community in focus in order to address mental health issues – also act as barriers in conducting linguistically and culturally sensitive research. A review of 20 studies by Stacciarini, Shattell, Coady, and Wiens (2011) reported that the use of community-based participatory research (CBPR) to address mental health issues with minorities reveals the need for new and innovative approaches to address culturally unique issues. They explained that the use of culturally compatible language or emphasis on general mental health or wellness promotion is recommended to overcome the challenges (e.g. stigma) faced in addressing mental health issues within minority populations. The authors suggested shifting from an illness or health service perspective to a wellness approach. As such, the need for culturally sensitive and linguistically compatible mental health services cannot be understated.

In summary, given the empirical evidence regarding the difference in help-seeking behaviors and referral patterns as well as the disparities in mental health service utilization among ethnic minorities, the outcome of the research on ES programs or culturally tailored interventions shows favorable results in the form of increased rates of utilization and decreased premature dropout rates. Table 2.5 below provides a summary of studies focused on matching client and clinician in language, culture, and cognitive orientation.

Table 2.5

*Research Summary of Matching Client and Clinician in Language, Culture, and Cognitive Orientation*

Authors	Research Focus	Methodology	Findings
Gamst, Dana, Der-Karabetian, & Kramer(2004)	Investigate the effects of client ethnicity and client-counselor ethnic match on treatment outcomes of child and adolescent mental health clients	Quantitative – ANCOVA analysis of child and adolescent community mental health center clients (N = 1946)	No differences observed among client ethnicities, age groups, or ethnic match on treatment outcomes  Fewer mental health visits for ethnically matched African American child and adolescent clients than their non-matched counterparts
Lin (2011)	Examine differences in premature dropout rates from mental health therapy among various Asian American groups after controlling for variables	Quantitative – Chi-square analysis of data of outpatients at an Asian-oriented ethnic-specific mental health program in Northern California	Recent immigrant arrivals, poorer clients more likely to drop out  Employed clients, self-referred clients, clients living outside the family home, clients with psychotic diagnoses, clients matched with therapist who spoke their primary language, and clients matched with a therapist of the same ethnicity less likely to drop out
Sue, Fujino, Hu, Takeuchi, & Zane (1991)	Examine relationship between therapist-client match and outcomes of Asian Americans, African Americans, Hispanic Americans and White Americans	Quantitative – regression analysis  Data from Automated Information System (AIS) of LA County Department of Mental health; 600,000 different clients between 1973-1988; independent variables: client-clinician ethnic match, language match, gender match; dependent variables: premature termination, number of sessions, treatment outcome	Service utilization: Asian Americans and Hispanic Americans underrepresented, African Americans overrepresented  Premature termination: client ethnicity not a predictor; ethnic match a significant predictor to lower premature dropout rates for all groups other than African Americans  Number of sessions: ethnic match significant predictor for greater number of sessions for all groups  Treatment outcomes: ethnic match significant predictor for Mexican Americans; ethnic match approaches significance ( $p < 0.6$ ) for Asian Americans
Mier et al. (2010)	Examine issues related to intervention tailoring for ethnic minorities	Qualitative case study – descriptive analysis of survey of researchers (N = 17) of Health	Tailoring strategies: match intervention with client schedules; deliver intervention to accessible locations or meet client

		Maintenance Consortium (HMC) and follow-up telephone interviews	transportation needs; provide culturally informed treatment  Culturally tailored interventions should be individually based
Ziguras, Klimidis, Lewis, & Stuart (2003)	Examine effects of matching language and culture of ethnic clients in mental health service	Quasi-experimental design (N = 2935) – compare service data (1997-1999) in Australia among (1) ethnic minorities who were matched with bilingual, bicultural clinicians, (2) ethnic minorities who were not matched, and (3) clients who are English speakers	Matching ethnic clients with bilingual clinician associated with reduced need for crisis intervention and fewer inpatient interventions
Stacciarini, Shattell, Coady, & Wiens (2011)	Synthesize studies employing community-based participatory research (CBPR) approach to address mental health problems of minority populations	Meta-analysis; review of studies related to CBPR  Search of databases – CINAHL, PsychINFO, Pubmed, Google Scholar; studies selected based on inclusion and exclusion criteria  Twenty studies selected (Table 1) for in-depth review based on inclusion and exclusion criteria	CBPR approach has potential to reduce mental health treatment disparities among minorities; CBPR approach associated with paradigm shift from health service perspective to community-driven interventions

### **Mental Health Needs among Asian Americans**

The previous sections of this literature review clarified the impact of the immigration experience on one's mental health, the difference in help seeking behavior and referral patterns between different ethnic groups, the disparities in mental health service utilization among immigrant minority populations and other populations, and how matching the language, culture, and cognitive orientation of client and clinician increases the effectiveness of the treatment. The focus of the literature review now narrows to Asian American immigrant communities, highlighting the underutilization of mental health services by such populations due to the lack of bicultural and bilingual services. Here, the term Asian American is used to refer to foreign-born

Asian Americans for whom the challenges of language and culture are of vital importance. First, the mental health issues of foreign-born Asian American immigrants in general are briefly mentioned, followed by a discussion of perceptions and attitudes toward mental health issues among Asian Americans. Finally, the underutilization of mental health services among Asian Americans in particular is examined.

### **Foreign-Born Asian American Immigrants and Mental Health Issues**

Despite the seriousness of mental health needs and the underutilization of public mental health services by Asian Americans (Akutsu et al., 1996; Kaltman et al., 2011; S. Lee et al., 2011; Sue et al., 1991; Ziguras et al., 2003), there is a lack of research specific to Asian Americans and different Asian American subgroups. Multiple factors may contribute to the relative lack of research in the area of mental health theory and practice for these populations. One factor may be that Asian Americans make up a relatively small proportion of the total U.S. population, comprising approximately 5% of the nation's residents (U.S. Census Bureau, 2012).

However, reports by the U.S. Census Bureau in recent years reveal that Asian Americans are the fastest growing minority group (K. H. Lee, 2010; Mier et al., 2010). The U.S. minority population growth by race as published by the White House Initiative on Asian American and Pacific Islanders (AAPI) shown below, presents the AAPI community to be at 15.9 million in 2010 with the total non-Hispanic White American population reaching just shy of 197.8 million. It is projected that the AAPI community will reach 34.4 million by 2060 (U.S. Census Bureau, 2012).

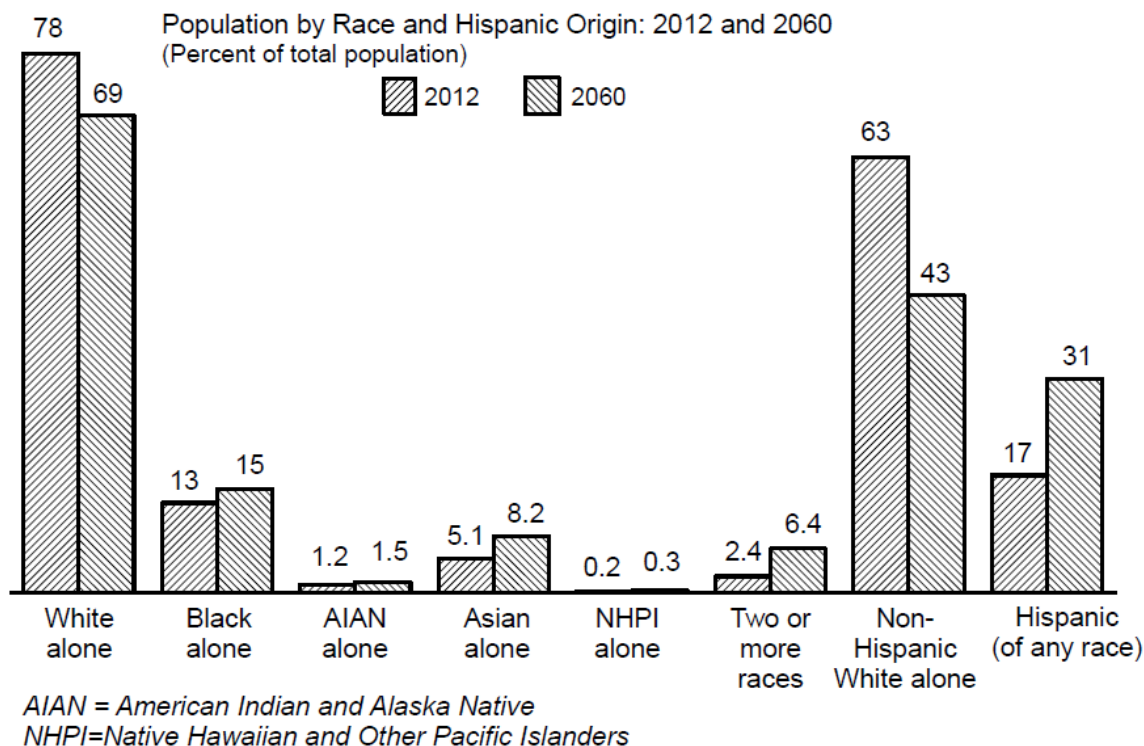


Figure 2.6. Adapted from U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now. Retrieved from [www.census.gov/newsroom/releases/archives/population/cb12-243.html](http://www.census.gov/newsroom/releases/archives/population/cb12-243.html)

Another factor may be that Asian Americans are often treated as an aggregated unit despite the fact that Asian Americans are highly diverse, with more than 43 ethnic subgroups, which poses researchers with the challenge of unique languages in each research participant group (K. H. Lee, 2010; Leong & Lau, 2001). Each of these subgroups has a unique language, culture, and immigration history in the United States. Therefore, focusing on mental health issues relating to any specific AAPI immigrant community is a challenge. Nonetheless, the prevalence of mental health problems among Asian Americans is noted in several available studies (Kaltman et al., 2011; K. H. Lee, 2011; S. Lee et al., 2009; S. Lee et al., 2011; Sue et al., 1991; Ziguras et al., 2003).

### **Perceptions and Attitudes toward Mental Health Issues among Asian Americans**

The stigma towards mental health problems has existed across the ages of time and different cultures of various global communities (Corrigan, 2012; Corrigan et al., 2001; Gilbert et al., 2007). However, the largely shame-based cultures of the Asian American community in particular suffer from the effects of the stigmas against mental illness (Chu & Sue, 2011; Gilbert et al., 2007; Lam et al., 2010; S. Lee et al., 2009). S. Lee et al. (2009) posited that in Asian cultures, mental health problems are traditionally viewed as a result of one's inability to control oneself and thus a reason for shame, leading to a reluctance to seek help openly. Seeking mental health help is often regarded as taboo leading to hiding, neglecting, and/or denying having such issues instead of seeking help (S. Lee et al., 2009). Chu and Sue (2011) suggested that among Asian Americans, especially older adults, mental health problems are viewed as weaknesses which bring shame to a family. Citing Eisenberg, Golberstein, and Gollust (2007), they indicated that due to greater personal stigma and lower stigma tolerance, Asian Americans are less likely to seek help.

Tata and Leong (1994) conducted a study to examine and predict the help-seeking attitudes of Chinese Americans at a large Midwestern university. The data was gathered through questionnaires based on the following three scales – a modified Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH), a modified Suinn-Lew Asian Self-Identity Acculturation scale (SL-ASIA), and the Network Orientation Scale (NOS). Using quantitative techniques including regression analysis, *t*-tests and  $\chi^2$ -tests, the authors examined the predictor variables of gender, individualism, social network orientation, and acculturation in relation to the help-seeking attitudes of the Chinese American students ( $N = 219$ ) in a Midwestern university. The findings indicated that all of the variables were significant predictors of help seeking



attitudes. Regarding gender, women were found to be more likely to have a positive attitude towards seeking help. Individualism showed an inverse relationship – more negative scores on the individualism scale correlated with more positive attitudes towards seeking help. Social network orientation also showed an inverse relation, with negative scores correlating with a positive attitude. Finally, acculturation revealed a direct relationship – higher acculturation correlated with positive attitudes towards seeking help.

Even though Tata and Leong (1994) did not seek to generalize the findings beyond the study's sample population, their findings may be applicable to other Asian American populations such as Korean Americans in as far as help-seeking attitudes are concerned. Interestingly, Evans et al. (2012) found that the service needs and utilization of Asian Americans and Pacific Islanders (AAPIs) are more alike than different when compared to non-AAPI patients. A secondary analysis of the data (i.e. demographic characteristics, treatment experiences, and one-year outcomes) for 298 AAPIs and a matched comparison group of 298 non-AAPI patients from 44 community-based substance abuse treatment sites in three states revealed that after controlling for baseline problem severity, no significant differences were found between the AAPI and non-AAPI patients in terms of retention, completion, and outcome of treatment. Such findings, though limited to the area of substance abuse treatment, not only debunk the model minority stereotype of AAPI, but also confirm that similar service needs, experience of treatment, and service utilization exist.

Table 2.6 provides a brief summary of research related to Asian Americans and mental illness prevalence, perceptions, and help-seeking behaviors. Although Asian Americans currently make up only a small percentage of the U.S. population at large, the Asian American population is comprised of the country's fastest growing minority groups and thus understanding

the prevalence of mental health problems among them is of significant importance. However, the perceptions and attitudes toward mental health issues among Asian Americans present challenges in meeting their service needs due to the stigma associated with mental illness. Research also shows that these perceptions are associated with gender, social network orientation, education, and the degree of acculturation experienced by individual members of the Asian American population.

Table 2.6

*Research Summary of Asian Americans and Mental Illness Perceptions and Help-Seeking Behaviors*

Study	Research Focus	Methodology	Findings
Gilbert et al. (2007)	Explore differences between Asian and non-Asian American students in shame-focused attitudes towards mental health problems	Quantitative – Cronbach's alphas, <i>t</i> -tests, MANCOVA  Data and analysis: Administer a series of self-report scales to female university students including those who self-identified as Asian Americans: Attitudes Toward Mental Health Problems (ATMHP) scale, Asian Values Scale (AVS), Disclosure Expectation Scale (DES), Confidentiality Scale (CS)	Personal or internalized shame – no significant differences among student groups  Reflected shame – Asian American students have significantly higher concerns about bringing shame on their families due the mental health problems  Perceived threat and utility of disclosing information in counseling situations – no significant differences  Fear of confidentiality – Asian American students have higher concerns about confidentiality when disclosing information to others; correlates with belief that one's community views mental health problems negatively
Lam et al. (2010)	Raise awareness of attitudes toward mental illness prevalent in Chinese culture and provide suggestions to counselors when working with Chinese consumers	Descriptive – Describe lay theories on mental illness in Chinese culture and their implications on self-seeking behaviors	Lay theories prevalent in Chinese culture (e.g., Confucianism, Taoism, Buddhism, Shamanism) associated with self-stigma and also associated with family and public stigma (likely due to emphasis on collectivism typical of Chinese lay theories); lay theories affect self-seeking behaviors of individuals; important to examine lay beliefs about mental illness and stigma in order to understand attitudes and social behaviors of clients
S. Lee et al. (2009)	Examine mental health problems, status, barriers, and potential solutions in Asian American young adults.	Qualitative – use qualitative data software (Max QDA 2007) to organize data for analysis  Data: collected from focus groups with 1.5 or 2 <sup>nd</sup> generation young adults (N = 17, age 18 to 30) from eight	Emergent themes identified: prevalence of mental health problems among Asian Americans, definition/perception of mental health, potential sources of stress affecting mental health, mental health help-seeking behavior  Prevalence of mental health problems: participants do not often hear of problems; Asians tend to view mental health problems as

		Asian American (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, Vietnamese) communities; research team to code emergent themes of focus group discussions	<p>taboo</p> <p>Perception of mental health: in Asian cultures, mental health is viewed as something under individual's control; therefore, having mental health problems associated with individual's fault and shame</p> <p>Sources of stress: parental pressure to succeed; difficulty in balancing two different cultures and communicating with parents; family obligations and expectations based on strong family values; discrimination/isolation in the dominant culture</p> <p>Mental health problem help-seeking behavior: generally do not seek professional help or help from family; typically depend on religion, trusted friends, and significant others</p> <p>Deterrents to mental health help seeking: stigma; lack of clinicians that match ethnicity and language</p>
Tata & Leong (1994)	Examine patterns of help-seeking attitudes of Chinese American students	<p>Quantitative: regression analysis, <i>t</i>-tests, and chi-square</p> <p>Data: Survey of Chinese American students (N = 219) conducted via questionnaires based on scales: modified Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale; modified Suinn-Lew Asian Self-Identity Acculturation (SL-ASIA) scale; Network Orientation Scale (NOS)</p>	Significant predictors of help-seeking attitudes among Chinese American students: Gender (women associated with higher positive attitudes); individualism (inverse relationship – lower score correlate with higher positive attitude); social network orientation (inverse relationship – lower score correlate with higher positive attitude); acculturation (direct relationship – higher acculturation level correlate with higher positive attitude)
Yeung et al. (2004)	Examine relationship between integrating psychiatry and primary healthcare and referral to and treatment acceptability of mental health services among Chinese Americans	<p>Quantitative – <i>t</i>-test, chi-square test analyses</p> <p>Comparison of pre- and post-training referral records of a community health center (training of primary care physicians and nurses in cultural sensitivity)</p>	Significant increase in the percentage of patients referred for mental health services post-training; significant increase in patients showing up for initial mental health evaluation post-training

## Underutilization of Mental Health Services among Asian Americans

The underutilization of mental health services by Asian Americans as an immigrant minority group has been consistently documented (Chu & Sue, 2011; Herrick & Brown, 1998; Le Meyer et al., 2009; Zhang & Snowden, 1999). A study conducted by Matsuoka et al. (1997) is especially noteworthy. The authors conducted a statistical analysis of 1986 survey data from

the National Institute of Mental Health to ascertain an overall pattern of utilization of mental health services by Asian Americans/Pacific Islanders (AAPI). The authors indicated that the data reflected a complete enumeration of clients and/or patients of all organizations within the United States (Matsuoka et al., 1997). The sheer scope and magnitude of the data lends credibility and validity to the study.

At the national level, the study found that the proportion of AAPIs utilizing mental health services was a third of the proportion of White Americans (.41% vs. 1.24%) when all types of mental health services in all types of facilities were combined. A significant difference in utilization rates persisted even when services were examined individually (e.g., outpatient – .34% vs. 1.06%; inpatient – .02% vs. .07%) (Matsuoka et al., 1997).

The aforementioned study clearly indicates significant underutilization of mental health services by the AAPI population. However, the study does not offer possible reasons for the underutilization findings as it was not part of the study's objectives. Lack of accessibility and barriers to culturally responsive mental health services have received considerable attention as possible reasons (Herrick & Brown, 1998; S. Lee et al., 2009; Le Meyer et al., 2009; Leong & Lau, 2001; Lin, 2011; Park, 2012; Wu et al., 2009; Ziguras et al., 2003).

Le Meyer et al. (2009) explored possible reasons for such underutilization while conducting an analysis of 368 Asian Americans including but not limited to those of Chinese, Filipino, and Vietnamese descent who met the criteria for DSM-IV disorder. The dependent variable measured was the use of specialty mental health services including services delivered by mental health professionals such as psychiatrists and psychologists. Independent variables were primary care services such as those delivered by a general practitioner and nurses and alternative services such as those provided by religious advisors. The authors conducted regression analysis

to identify factors associated with mental health service use among foreign and US-born and Asian immigrant populations. The study results revealed (1) a significant underutilization of mental health services among Asian Americans in general, (2) a more acute underutilization among Asian American immigrants, and that (3) twice the incidence of the utilization of such services by US-born as opposed to immigrant Asian Americans. While the use of primary care services was identified as being significantly associated with the use of mental health services among U.S.-born Asian Americans, the same could not be said for foreign-born Asian Americans. However, both US and foreign-born Asian Americans were found to make significant use of alternative services (e.g. religious/spiritual advisor, Eastern medicines, chiropractor, etc.), with the nature of the influence varying based on the English proficiency of the individuals. The authors stated that these findings imply the need for community education and outreach efforts with a focus on networks and referral bridges with alternative health care providers.

S. Lee et al. (2009) conducted two focus group discussions among 1.5 and 2<sup>nd</sup> generation young adult Asian Americans ( $N = 17$ , see Table 2.6) to obtain information on issues related to mental health. The authors identified six different deterrents to help-seeking as it relates to mental health issues among Asian Americans: (1) the stigma associated with mental health problems, (2) a lack of awareness of the issues related to mental health problems, (3) a desire to protect family members by avoiding burdening them, (4) a lack of mental health professionals with linguistic and cultural competency (e.g. accessibility), (5) a lack of parental knowledge regarding youth and related mental health issues, and (6) the cost of accessing mental health care (e.g. affordability).

According to S. Lee et al. (2009), the stereotypical view that Asian Americans are reluctant to seek mental health services in response to psychological problems is only partly true. It is more accurately viewed as a complex issue rather than simply one of Asian Americans being unwilling to receive psychological help. A comprehensive understanding of the multiple factors involved in utilization is lacking and needs to be further explored using a nationally representative sample.

Table 2.7 below provides a summary of the aforementioned studies related to utilization of mental health services among Asian Americans. Generally, Asian Americans underutilize mental health services, a phenomenon associated with several cultural factors. However, there are other significant factors involved in this proclivity including English proficiency (communication), availability of primary health services, availability of alternative services, practical factors (e.g. transportation and affordability), and lack of awareness. Some of these factors may be especially acute for Korean Americans. For example, communication may play a more significant role since Korean Americans are relatively more recent arrivals and thus may have generally lower English proficiency. The next section discusses these and other issues as they relate to Korean Americans.

Table 2.7

*Research Summary the Utilization of Mental Health Services by Asian Americans*

Study	Research Focus	Methodology	Findings
Le Meyer et al. (2009)	Examine factors related to underutilization of specialty mental health services	Quantitative – logistic regression analyses, <i>t</i> -tests  Data: derived from National Latino and Asian American Study (NLAAS) conducted between May 2002 and December 2003; examine data of individuals with psychiatric disorders,	Asian Americans underutilize mental health services  Underutilization especially acute among foreign-born Asian Americans – U.S.-born Asian American use of mental health services almost twice that of foreign-born Asian Americans

		distinguish between US- and foreign-born individuals	
S. Lee et al. (2011)	Assess health needs of Asian American communities	<p>Qualitative – use qualitative data software (Max QDA 2007) to analyze data and code emergent themes</p> <p>Data: collected from 19 focus groups from 13 Asian American communities (Asian Indian, Burmese, Cambodian, Chinese, Filipino, Indonesian, Japanese, Korean, Nepali, Pakistani, Taiwanese, Thai, Vietnamese) communities; research team to code emergent themes of focus group discussions</p>	<p>Emergent themes identified: health needs with two subthemes – general health, mental health</p> <p>Mental health issues: discussing mental health issues generally considered as taboo among Asian Americans</p> <p>Deterrents to mental health help-seeking: stigma associated with mental illness; lack of insurance coverage; lack of clinicians that can offer linguistically and culturally appropriate care; lack of awareness; parents' lack of knowledge of how to identify mental health issues in their children</p>
Leong & Lau (2001)	Examine barriers to providing effective mental health services to Asian Americans	<p>Meta-analysis – review of literature consistent with stages 2 (help-seeking behaviors), 3 (diagnosis and evaluation), and 4 (psychotherapeutic services) of Rogler, Malgady, and Rodriguez's (1989) framework for understanding mental health of ethnic minorities</p>	<p>Barriers to initial help-seeking: cultural influences on mental health and illnesses; affective response to emotional problems; cultural values in communication norms</p> <p>Mental health evaluations: threats to cultural validity; therapist bias in clinical judgment; language of assessment; cultural factors influencing symptoms</p> <p>Psychotherapeutic services: cultural factors that operate in the evaluation process also enter the therapeutic process</p>
Barreto & Segal (2005)	Explore use of mental health services by Asian Americans and other ethnic populations	<p>Quantitative – linear regression analyses, chi-square test, one-way ANOVA</p> <p>Data: obtained from clients (N = 104,773) of age <math>\geq 18</math> from six counties in California</p>	<p>Significant differences in service use among different categories of Asian Americans</p>
Matsuoka, Breaux, & Ryujin (1997)	Ascertain overall national pattern of utilization of mental health services by Asian Americans / Pacific Islanders (AAPI).	<p>Quantitative – chi-square test</p> <p>Data: 1986 National Institute of Mental Health survey data; based on complete enumeration within U.S. of clients of organizations</p>	<p>Significantly smaller proportion of AAPI utilize all types of mental health services than Euro Americans – usage rate about one-third of Euro Americans (0.41% vs. 1.24%)</p> <p>Extensive differences persist among different types of services examined (outpatient, inpatient, residential, residential support care, partial care)</p>

### Mental Health Needs among Korean Americans

In this final section of the literature review, the focus is further narrowed to a particular Asian American immigrant community. Because the majority of Korean Americans currently in

the U.S. are immigrants, the scope of this study is limited to Korean Americans who were born in Korea but later immigrated to the U.S. with a particular focus given to the seriousness of mental health needs of Korean Americans. Their political and economic history and short immigration period are relatively unique as compared to other Asian Americans, and thus place them at a greater vulnerability to stresses and other mental health problems. The section concludes with a table summarizing the limited literature available on Korean American immigrants and their mental health issues.

Koreans Americans as a group are recent arrivals to the U.S. relative to other Asian Americans. According to Bernstein (2007), the number of people immigrating to the U.S. from Korea increased dramatically from 70,000 in 1970 to over 800,000 in 1990. As of 2000, 8 out of 10 Korean Americans in New York City had been born in Korea and 43% had arrived since 1990 or later. Wu et al. (2009) reported that, between 1990 and 2000, the Korean American population was the fastest growing of all Asian American subgroups, and that two out of three Korean Americans were first generation immigrants. Being the most recent arrivals, it is not surprising that Korean Americans show higher rates of depression and anxiety relative to other Asian Americans.

### **Korean Americans and Mental Health Service Needs**

Studies of Korean American immigrants are extremely limited. Even when included in studies, Korean Americans are often aggregated into the category of Asian Americans (K. H. Lee, 2010; Leong & Lau, 2001; Wu et al., 2009). K. H. Lee (2010) reported that Korean Americans are the least studied group among all Asian American subpopulations, relative to their population size among U.S. minority groups. In searching for studies on the seriousness of



mental health needs and utilization status of public service, very little literature is available regarding the Korean American population in comparison to other Asian American groups.

Nonetheless, the small body of available literature does spotlight the seriousness of the mental health needs and limited social and economic resources of Korean Americans (Bernstein, 2007; K. H. Lee, 2010; Park, 2012; Park & Bernstein, 2008; Wu et al., 2009). One significant reason is that, relative to other Asian Americans, Korean Americans have a relatively short political, economic, and immigration history in the US, with concurrent increased assimilation stress and vulnerability to psychological problems having been noted (Kuo, 1984). Research indicates that Korean American immigrants have a higher rate of psychological problems and mental health care needs than other Asian Americans (K. H. Lee, 2010; Wu et al., 2009). For example, Korean Americans have been found to have a higher incidence of depressive symptoms (Kuo, 1984), more clinically elevated MMPI scores, more psychotic symptoms, and poorer treatment outcomes (W. Kim, 2002; Zane et al., 1994) than other groups of East Asian descent. Additionally, Leong and Lau (2001) suggested that the high levels of need among Korean Americans are similar to immigrants of Southeast Asian descent, with similar patterns in psychiatric diagnoses.

It is worth noting that elderly Korean Americans have a unique set of life experiences as a group. They have lived through two major wars – the second Sino-Japanese War from 1937 to 1945 and the Korean War from 1950 to 1953 – and many of them were born and raised during the time of the Japanese occupation of Korea from 1910 to 1945. The timing of this older generation's birth and development in such a period of national political instability and economic and social upheaval has left them vulnerable to anxiety and depression due to trauma, loss, and grief (Hall, 2010). Such a history serves as the backdrop for the second wave of significant

stresses that first-generation Korean American immigrants are hit with when undergoing the immigration and assimilation process.

Consequently, immigration and assimilation to a new language and culture undoubtedly add additional dimensions of stress and vulnerability to psychological problems. It can also be said that even some younger Korean Americans are indirectly impacted by such a history, through their exposure to a high level of familial anxiety. As mentioned earlier, such a context supports research findings that point to Korean American immigrants having a higher rate of psychological problems and mental health care needs when compared to other Asian Americans (K. H. Lee, 2010; Wu et al., 2009).

### **Mental Health Service Utilization and Perceptions and Attitudes toward Mental Health Issues among Korean Americans**

According to Park and Bernstein (2008), depression is a major mental health problem prevalent among the immigrant population and Korean American immigrants are at high risk for it. However, despite the prevalence of depressive symptoms, the authors pointed out that Korean Americans rarely reveal their depressive symptoms due to the stigma associated with mental health illness in Korean culture, which is consistent with the research findings involving Asian Americans mentioned in the previous section. Park and Bernstein posited that this fact, coupled with a lack of culturally sensitive treatment, results in the underutilization of mental health services by Korean American immigrants.

Other researchers have also found a high prevalence of depression and anxiety among Korean American immigrants (Bernstein, 2007; Cheung et al., 2011; K. H. Lee, 2010; Park & Bernstein, 2008; Shin, 2002; Sin, Jordan, & Park, 2011). K. H. Lee (2010) reported that Korean Americans suffer higher levels of depression and anxiety and have greater difficulties in

communication than other Asian Americans. Wu et al. (2009) studied several Asian American subgroups including Chinese, Vietnamese, Filipino, Indian, Japanese, and Korean Americans. They reported that among these subgroups, Korean Americans had the highest rate of experiencing difficulty in communication with their doctors. The tendencies of Korean Americans, to be reluctant to utilize mental health services and to delay in obtaining services, and prematurely terminate services (K. H. Lee, 2010) likely exacerbated the issue.

This reluctance and delay is evident in a study that investigated the determinants of attitudes held by older Korean Americans toward mental health services (Jang, Kim, Hansen, & Chiriboga, 2007). Jang et al. (2007) conducted a survey of Korean Americans age 60 or older ( $N = 472$ ) using questions from the Attitudes toward Seeking Professional Psychological Help Scale and Center for Epidemiologic Studies Depression Scale. They found that shorter time spent in U.S. is associated with higher levels of depressive symptoms and more negative attitudes toward mental health services.

Park and Bernstein (2008) offer some helpful suggestions. They noted that Korean Americans tend to express depression through somatic symptoms, and thus tend to seek medical treatment rather than psychiatric treatment. They postulated that early assessment in a primary care setting could be helpful. Korean Americans in general and older Korean Americans in particular also tend to value family cohesion and filial piety, necessitating collaboration between the practitioner and family members. In addition, Park and Bernstein noted that churches play an important role in the lives of many Korean Americans, meaning that the practitioner may need to assess involvement in church activities on a client-by-client basis. This latter suggestion is addressed in the present research that explores community- and faith-based mental health services for this population.

### **Korean Americans and Help-seeking Behaviors for Mental Health Services**

Regarding the reluctance of Korean Americans to utilize mental health services, Bernstein (2007) pointed out that, among Korean Americans, mental health issues are often hidden and seeking help for them is frequently discouraged by family and friends. The author speculated that this is a result of the strong influence of Confucianism, which values family integrity, education, financial stability, and strong moral standards. Thus, Korean Americans may be discouraged from seeking help in part owing to the possibility that such actions may bring shame and dishonor to their family. Again, this is not unlike Asian Americans in general.

As mentioned in the previous section on Asian Americans, some studies have focused on the help-seeking behaviors of minorities, including Korean Americans (Akutsu et al., 1996; K. H. Lee, 2010). K. H. Lee (2010), for example, sought to identify the early stages of help-seeking behaviors by Korean Americans with depression or anxiety, and also to identify predictors of each help-seeking behavior by Korean Americans with depression or anxiety. K. H. Lee analyzed data from Korean Americans diagnosed with depression or *anxiety* ( $N = 59$ ) and also conducted a secondary analysis of existing data from a survey on Disparity in Quality of Health Care (DHCQ) conducted in 2001. Three types of help-seeking behaviors were identified in the study: self-help behavior, informal help-seeking behavior (e.g. family, friends, coworkers, etc.), and formal help-seeking behavior (e.g. health care providers, complementary and alternative medicine use). Korean Americans with depression or anxiety in the aforementioned study were mostly female, married, and over 40 years of age. Interestingly, the majority had high levels of education and yet were also socially disadvantaged.

K. H. Lee (2010) found that among the self-help behaviors, printed materials were preferred over those obtained via the Internet. The majority relied on informal help-seeking and

all used complementary and alternative medicine at least once. The majority were not able to seek help from health care professionals. Self-help behaviors were mainly affected by predisposing factors including demographic variables, social structures, and health beliefs. Informal help-seeking behaviors were more influenced by enabling factors such as income and insurance coverage. Difficulties in seeking help from health care professionals were associated with both predisposing and enabling factors.

In a qualitative study exploring individual and contextual barriers to seeking mental health services among Korean American immigrant women, Wu et al. (2009) found that due to their living in a male-dominated, Confucian culture, Korean American women may be at higher risk of experiencing mental health problems than Korean American men. Korean American women may also face more barriers to service-seeking than Korean American men owing to the expectations of Korean society that women care for children and the elderly and assume sole responsibility for household duties such as cooking and cleaning. In sum, barriers identified by the research participants (both Korean American women and Korean American providers) included language problems, time and financial limitations, lack of transportation, lack of family support, and lack of knowledge about mental health problems and available services.

### **Korean Americans and Barriers to Accessing Mental Health Services**

The topic of barriers to accessing mental health services has already been discussed in the previous sections on ethnic minorities and Asian Americans in particular. The study conducted by Wu et al. (2009) is worth mentioning here as well because it also identified various individual and contextual barriers to seeking mental health services that are specific to Korean American immigrant women. The study consisted of focus group interviews with 27 Korean American participants, two groups of providers and two groups of community women. The study

identified numerous barriers including language and cultural differences, lack of resources (time, transportation, and funding for local community agencies), lack of knowledge, lack of partnership with churches, and social stigma.

To reduce such barriers, Wu et al. (2009) recommended increasing the availability of ethnically and linguistically matched mental health services and further training for providers. They also suggested making use of community outreach and education efforts and incorporating churches into that effort. In addition, sensitivity to the need of help-seekers to save face and efforts to assure confidentiality were deemed important. It should be noted that the importance of the role of churches and their pastors in collaborating with community agencies has been emphasized by many participants in research involving Korean Americans (Cheung et al., 2011; Lam et al., 2010; Park, 2012; Rhee, Chang, & Youn, 2003; Wu et al., 2009). To that end, the next section is devoted to discussing the importance of faith-based mental health services.

Table 2.8 provides a summary of studies related to Korean Americans and mental health. Korean Americans are generally like other Asian Americans in that they underutilize mental health services. Barriers to services utilization included similar cultural and practical factors. However, unlike other Asian American groups such as Chinese and Japanese Americans, Korean Americans are relatively recent arrivals to the US. This is evidenced by the fact that the majority of Korean Americans in the U.S. are immigrants. Also, Korea's relatively modern history makes the Korean American experience unique. Many Korean Americans have lived through the Japanese occupation, the Second World War, the Korean War and/or the period of rapid economic development that Korea experienced during the second half of the twentieth century. Having lived through these events of significant upheaval and change makes Korean Americans especially vulnerable to suffering from mental health-related issues.

Table 2.8

*Research Summary of Korean Americans and Mental Health*

Study	Research Focus	Methodology	Findings
Park & Bernstein (2008)	Examine/describe clinical implications of Korean culture in treatment of depression among Korean American immigrants	Meta-analysis – literature review of: Korean American immigration trends; Korean culture and values; acculturation and its relation to depression; manifestation in Korean American immigrants with depression; help-seeking behaviors; implications	<p>Immigration trends: Korean Americans one of the fastest growing groups in US; Korean Americans in U.S. largely foreign born, concentrated in major metropolitan areas</p> <p>Korean culture and values: emphasize family integrity, group conformity (family/group over individual), traditional gender and marital roles (male-dominated)</p> <p>Acculturation and depression: depression higher among Korean Americans due to acculturative stress (stress of adapting to host culture); social support as a moderating factor to depression</p> <p>Depression symptom manifestation: fear of stigma associated with mental illness; expressed via somatic symptoms</p> <p>Help-seeking: Korean American immigrants with depression rarely seek treatment (tendency to report somatic symptoms); tendency to seek self-help, informal services (to keep mental illness a secret); seek medical over psychiatric services</p> <p>Implications: provide education, culture-specific responses; social support</p>
Bernstein (2007)	Identify perceptions of mental health/illness, help-seeking and coping behaviors of Korean American immigrants	<p>Qualitative – description of survey data on selected topics</p> <p>Data: Advertise availability of seminars on selected topics; provide seminars on topics; collect data through a survey of seminar participants (N = 34) on the seminar topics</p>	<p>Selected seminar topics: (a) stress and its impact on Korean American immigrant women, (b) child and adolescent problems among Korean American immigrants, (c) alcoholism and its impact on Korean American immigrants, and (d) Korean American women's lives as a wife, mother, and woman</p> <p>Barriers to using services: refusal or lack of motivation to seek services; financial considerations; general difficulty; lack of trustworthy organizations</p> <p>Coping strategies: endurance/patience; spiritual counseling/religion; family support</p> <p>Suggestion: make available culturally congruent mental health services to enhance access and utilization by this community</p>
Zane, Hatanaka, Park, & Akutsu (1994)	Examine effectiveness of parallel services for Asian American and White American outpatients with respect to client characteristics, types of services utilized, and service effectiveness	<p>Quantitative – regression analysis, <i>t</i>-tests</p> <p>Data: collected on clients (N = 885 – Chinese, Japanese, Filipino, Korean, Lao/Cambodian, Vietnamese, and White Americans)</p>	<p>Clinical characteristics: Different Asian American subgroups tend to have different types of clinical problems; Korean Americans have highest rate of psychotic disorders and lowest rate of nonpsychiatric disorders; Korean Americans enter treatment under significantly more psychosocial stress; pretherapy psychosocial stressors more severe for Korean Americans than other Asian Americans</p>

		seen as outpatients at a community mental health center in Los Angeles	Utilization: Asian and White Americans tend to have different ways of entering treatment  Suggest service effectiveness can be achieved through ethnically-tailored services
Cheung, Leung, & Cheung (2011)	Examine factors which may contribute to depressive symptoms and help-seeking behaviors among Korean Americans	Quantitative – chi-square test, <i>t</i> -test, regression analysis  Data: gathered from a needs assessment survey of Asian Americans in Houston metropolitan area (age ≥ 18); survey includes the Hopkins Symptoms Checklist (HSCL-25) to assess mental health issues	Rank of services preference for physical health among Korean Americans: physicians; herbalists; friends or family; religious consultation  Rank of services preference for mental health among Korean Americans: friends or family; religious consultation; physicians; herbalists; mental health professionals  Significant predictors of depression among Korean Americans: income, healthcare concerns, anxiety  Tendency among Korean Americans to seek advice about mental health issues from physicians, friends and non-mental health professionals (religious leaders)
Jang, Kim, Hansen, & Chiriboga (2007)	Examine attitudes of older Korean Americans toward mental health services	Quantitative – comparative analysis, chi-square test  Data: survey of Korean Americans (age ≥ 60) in Florida between 2005 and 2006 (final sample N = 472); survey includes questions from Attitudes toward Seeking Professional Psychological Help Scale Center for Epidemiologic Studies Depression Scale (CES-D)	Depressive symptoms of older Korean Americans higher than older adults of other racial/ethnic groups  Greater level of depressive symptoms associated with more negative attitudes toward mental health services  Depressive symptoms seen as barrier rather than need  Culturally-influenced personal beliefs play substantial role in shaping attitudes toward mental health services  Predictors: age, sex, marital status, education, length of residence in U.S.
Sin, Jordan, & Park (2011)	Examine perceptions of depression in Korean Americans	Quantitative – descriptive statistics  Data: focus groups (N = 28) of Korean Americans from Washington state; participant inclusion criteria – age ≥ 40, immigrant from Korea, living in Washington state	Knowledge of depression: Participants relate depression to mental illness, suicide; participants see symptoms of depression to include anxiousness, sadness, worthlessness, loneliness, isolation, lack of desire, lower self-esteem, stress accumulation; participants see causes of depression to include difficulties related to immigration (language barriers, lifestyle changes, cultural change, lower economic and social status)  Sources of stress: language barrier; inferior feelings; decreased self-esteem; lowered social status; lack of recognition from others; conflict and home and work; caregiver issues  Coping strategies: social interaction; faith; diligence
Wu, Kviz, & Miller (2009)	Examine perceptions about barriers to Korean American women seeking mental health services	Qualitative  Data: focus group consisting of 27 Korean American women comprised of health care providers	Individual barriers to seeking services among Korean American women: language problems; cultural differences between provider and client (women's role as the caretaker of family, male-female relationship, tendency to keep family problems private); lack of resources (time, finances, transportation); lack of knowledge of



		and lay community women; conduct and record discussions, transcribe, identify and code themes	<p>mental health problems and available services; lack of funding for community agencies; lack of partnership with churches; stigma</p> <p>Korean American women at more risk to experience barriers than men</p> <p>Participants' recommendations: support pastors, work with Korean American churches; provide community education; provide community outreach; make efforts to save face and assure confidentiality; provide resources to train more Korean American service providers</p>
Park (2012)	Examine experiences of Korean Americans who have considered entering therapy: (1) discover the ways that Korean Americans are introduced to therapy; (2) understand the reasons for their reluctance to enter therapy; (3) discuss the process of entering therapy despite initial reluctance	<p>Qualitative – phenomenological study</p> <p>Data: interviews and surveys of Korean Americans (N = 8, six women, two men, first and second generation, age 25 to 35); discussion of participants' experiences leading up to first therapy appointment</p>	<p>Severe emotional distress during significant life challenges associated with seeking more information about therapy</p> <p>Challenges to seeking therapy: anticipated social ramifications upon entering therapy; anxieties associated with meeting and communicating their problems to a stranger</p> <p>Participants more likely to enter therapy if their problems were seen as impacting their academic performance or career ambitions, problems are severe and unmanageable</p> <p>Other positive correlations: living in therapy-friendly environments with supportive friends who were participating in therapy; moving away from their parents; viewing therapy as a form of self-care on par with a medical visit</p>
Shin (2002)	Examine Korean American immigrants' help-seeking behaviors for depression to understand their underutilization of mental health services	<p>Qualitative</p> <p>Data gathering: focus group discussions with Korean American community leaders (N = 13) to obtain general picture of help-seeking behaviors of Korean American immigrants; focus group discussion with Korean American community members (N = 33) self-identified as experiencing depression; in-depth interviews community members (N = 24) self-reported to be experiencing depression</p>	<p>Non-help-seeking behaviors: self-help; overcome problem by will power; trying to forget</p> <p>Help-seeking from informal services (immediate family members, extended family members (aunts, uncles): family members attempt to keep problems within, family members offer medical solutions; family tolerance high for emotional distress so that help was not sought even for severe distress; pride and fear of confidentiality as factors contributing to limit help-seeking</p> <p>Help-seeking from formal services: seeking help from non-mental health services (herbalists, acupuncturists, general practitioners, family practitioners); few utilize social services or ministers</p> <p>Help-seeking from mental health services: require multiple steps – recognize there is a problem, decide external help is necessary, contact mental health service providers</p> <p>Barriers to seeking mental health services: stigma; gender and cultural appropriateness; lack of bilingual, bicultural services; finances; lack of knowledge; strong reluctance to accept depression</p>
K. H. Lee (2010)	Identify predictors of help-seeking behaviors and early stages of help-seeking behaviors in Korean Americans	Quantitative – descriptive statistics, <i>t</i> -tests, correlations, regression analysis; descriptive and cross-	Most extensively used help-seeking behaviors (in order): complementary and alternative medicines (CAMs); printed materials (self-help); family and friends (informal); Internet search (self-help)

with depression or anxiety	<p>sectional research design</p> <p>Data: weighted responses from Korean American adults (N = 59, age <math>\geq 18</math>) diagnosed with depression or anxiety; secondary analysis of existing data – survey on Disparity in Quality of Health Care (DHCQ) conducted in 2001</p> <p>Help-seeking behaviors: self-help, informal, formal</p> <p>Predisposing factors: demographics, social structure, health beliefs</p> <p>Enabling factors: income, health insurance, regular source of care</p>	<p>Majority did not perceive a need to seek help from health care professionals (HCPs)</p> <p>Self-help behaviors more affected by predisposing factors overall; informal help-seeking behaviors more affected by enabling factors overall; Korean Americans more likely to encounter difficulty in seeking help from HCPs; both predisposing and enabling factors significantly influence help-seeking behaviors from HCPs</p> <p>Informal help-seeking more associated with Korean Americans who were older, less educated, use Korean as their primary language, low income</p> <p>Suggestions to improve help-seeking behaviors: HCPs and researchers should make outreach efforts to Korean American immigrants; researchers should acknowledge the importance of CAM remedies and family support</p>
----------------------------	---	--

The literature review thus far has presented mental health issues pertaining to service delivery to (1) the immigrant minority community, (2) the Asian American community, and finally (3) the Korean American community. The following section addresses two additional relevant and significant topics for the present study: the faith-based and community-based aspects of mental health service delivery as they relate to meeting the mental health needs of the Korean American immigrant community.

### **Faith-based Mental Health Services**

Several studies in recent years exploring faith and the mental health of Korean American immigrants have asserted that religious faith improves stress management, reduces substance abuse, speeds the resolution of emotional conflict, and enhances overall psychological well-being and quality of life for this population (Choi-Kim, 2009; Lee & An, 2013; Lyu, 2009; Yi,

2007). The study of the intersection of faith and mental health would itself be a vast and multifaceted undertaking. The foregoing presentation of the literature review in this section, though, focuses narrowly on the significance of faith factors and the role of local churches within Korean American immigrant communities. In doing so, it is suggested that collaboration with local Korean American churches encourages utilization of and enhances the delivery of mental health services to Korean Americans.

### **The Role of Faith in the Korean American Immigrant Community**

The delivery of faith-based mental health services to Korean American Christians and to the Korean American community at large is an important issue. Korean Americans bring strong traditions from Korea to their lives in the US, including their faith traditions. Some of these religious traditions include a deep spiritual commitment to a life of prayer, high levels of commitment to family and community, the cultural values of persistence and patience, and reliance on Christian communities for spiritual hope and meaningful interpersonal relationships (McMinn et al., 2001).

For example, using a survey based on the Faith-Universal Religious Support Scale of Korean American Christians ( $N = 294$ ), Yi (2007) examined the effects of ethnic social support, religious support, and gratitude on the psychological well-being of Korean American Christians in California. The findings revealed that religious support is important in the lives of Korean American Christians. It found support from religious institutions, ethnic social support, and having a grateful attitude to be associated with better psychological well-being. Interestingly, even after controlling for ethnic social support, the effect of the religious institution's support on life satisfaction remained strong.

Another noteworthy study supports faith-based mental health services (Lee & An, 2013). Using a phenomenological approach, the authors interviewed 20 first generation Korean Americans age 55 and older within Korean American immigrant churches. The study explored the meaning of faith-based community support for these older Korean American adults and found that faith and faith-based communities (1) help immigrants deal with difficulties related to personal and social transition during their adaptation process, (2) serve as “social capital” (p. 450) in meeting not only spiritual needs but also physical and mental health needs, (3) provide comfort for physical pain and psychological fear, giving meaning to their experiences, and (4) offer a context of healing from “migratory stress and downward social mobility” (p. 455).

In this context, Korean American churches can be said to play an important role in making a positive contribution to the mental health of their people. Therefore, the following section focuses on the vehicle of the local Korean American church as an effective means of delivery of mental health services to Korean American immigrant communities. It should be noted that the nature of mental health services referred to here is assumed to be spiritually integrated in terms of the clinical content.

### **The Role of Local Korean American Immigrant Church**

Korean American churches serve as cultural centers for the Korean American community in which over 80% of individuals self-identify as Christians (M. Kim, 1990; Rhee et al., 2003). Therefore, for many Korean American immigrants, the church plays a significant role in the adjustment process of its members and meets not only spiritual, but also social and emotional needs (Choi-Kim, 2009; Kwon, Kim, & Warner, 2001; Lee & An, 2013; K. H. Lee, 2011; Rhee et al., 2003). Thus Korean Americans, perhaps not unlike members of other ethnic immigrant

communities, tend to turn first to the clergy of their faith community to deal with various mental health issues (Goldman, 2005; Lee & An, 2013).

Furthermore, Korean American pastors hold a position of respect and authority and exercise that position in guiding their congregation members with regard to mental health issues (Rhee et al., 2003). Given that a high percentage of individuals in the Korean American immigrant community identify themselves as Christians and pastors are given great authority and placed at a high level in the social hierarchy as respected community leaders (Rhee et al., 2003), Korean American pastors maybe a vital link in the chain of successful mental health service delivery.

In summary, support within a religious context strengthens the crucial role that Korean American churches and their pastors play in guiding individuals and families who are struggling with mental health issues. They are in a unique position to assist with the growing need for mental health services among the members of their congregations, indicating the need for a greater collaboration between Korean American churches and community mental health programs and organizations.

Table 2.9 summarizes several studies related to Korean Americans and the role that the local immigrant church and church leaders play in their lives. No empirical research studies have been found showing the effectiveness of collaboration with churches and other faith-based organizations in the delivery of mental health services. However, as the table indicates, faith does play an important role in the lives of the Korean American community. Therefore, it is important to collaborate with churches in meeting the mental health needs of Korean Americans.

Table 2.9

*Research Summary of Korean Americans and Faith*

Study	Research Focus	Methodology	Findings / Suggestions
Choi-Kim (2009)	Explore issues related to gender disparity in social and religious context of 1.5 and second generation Korean American women through understanding roots of patriarchal system in their home and churches	Qualitative – feminist research method and epistemology; social analysis and critical ethnography; oral narratives – listening to life histories of “underpowered” interviewees  Data: individual and focus group interviews of 1.5 and second generation Korean American women (N = 13); observation and facilitation of dialogue groups	Gender hierarchy based on male headship according to the book of Ephesians in the New Testament of the Bible – 1.5 and second generation Korean American women more economically independent than first generation counterparts, yet for most, greater involvement in church correlates with more conservative view of gender hierarchy; recognition of husband’s calling to sacrificially love the wife just as Christ sacrificially loved the church; Korean American women more likely than other American women to accept men’s authority rather than equality in marriage; Korean American women believe men and women are inherently different  Congregation performs significant role in Korean American women’s lives: enable stress release; enable bridging of psychological and ideological discord (contradictions between secularized Western values of equality and family’s patriarchal practices)  Conclusion: Korean American churches are both healing and oppressive to Korean American women
Lee & An (2013)	Examine how spiritual resources are being utilized by first generation Korean American elders; clarify religious and spiritual coping process for older Korean American immigrants	Qualitative – phenomenological study  Data: interviews and surveys of Korean immigrants (N = 20, first generation, age ≥ 55) on faith-based community support; series of open-ended questions on life challenges, support network, coping styles; specific questions regarding religion and spirituality, faith-based communities; data analyzed to identify themes, coded into meaning units and categorized	Major themes identified: religious practice; faith-based community as social center (even elderly non-Christian Korean Americans participate); spiritual needs and psychological support; meaning of suffering (e.g. pastoral visits to the sick); challenges, conflicts (conflicts among church members, between members and pastors, patriarchal leadership and women; hierarchical culture)  Spiritual and religious practices such as prayer, worship, and fellowship promote healthy behaviors among elderly Korean Americans  Findings suggest collaboration between social workers and clergy to promote outreach, education and prevention in meeting mental health service needs; limited English ability makes it critical that Korean American faith-based community be involved in providing social services; suggests Korean American churches should be more involved in local community
Lyu (2009)	Examine social marginality (not fully Korean and not fully American) and construct a communal contextual narrative approach	Qualitative – pastoral theological method; description of narrative therapy approaches; biblical narrative model	For those who feel marginalized, religious resources are helpful (citing Pargament, 1997); religious coping especially important for Korean Americans since over 70% of Korean Americans are affiliated with churches

	(encourage collaborative coping) to pastoral care in light of Korean American experiences (racism, sexism, intergenerational conflicts) related to acculturation process	Review of existing literature and author's personal experiences of racism, sexism, intergenerational conflicts as they relate to marginalization of Korean Americans	<p>Coping styles: self-directing (reliance on self); deferring (coping responsibility deferred to God); collaborative (individual and God active partners in coping)</p> <p>Korean Americans have more deferring, passive approach than White American counterparts</p> <p>Deferring style: tied to lower sense of control, lower self-esteem, higher intolerance of differences; deprives marginalized of personal agency</p> <p>Korean Americans have strong sense of collective identity (<i>uri</i>); can be harmful to some individuals in some instances</p> <p>In contrast, collaborative coping enhances self-agency (capacity to intervene in own lives and relationships); religious coping as cognitive process; coping connected with culture</p>
Yi (2007)	Examine psychological functioning of Korean-speaking Christians in America tied to ethnic social support, religious support, and individual attitude of gratitude	<p>Quantitative – multiple group factors analysis; zero-order correlations; hierarchical canonical analyses</p> <p>Data: collected through survey of participants at Korean American church in Southern California (N = 295, 181 women, 141 men, age 22 to 82)</p> <p>Survey: religious support based on Faith-Universal Religious Support Scale (FURSS); ethnic support based on Noh and Kaspar (2003) measure; depression based on Beck Depression Inventory-II (BDE-II); life satisfaction based on the Satisfaction with Life Scale (SWLS); gratitude based on Gratitude Questionnaire</p>	<p>Religious support plays important role for Korean American Christians</p> <p>Church-based social support negatively correlates with depression (citing Nooney and Woodrum (2002))</p> <p>Korean American women affiliated with church show lower degrees of depression, lower psycho physiological impairment, higher life-satisfaction</p> <p>Religious support relates positively to life satisfaction, negatively to depression; positive correlation with life satisfaction remains even after controlling for ethnic support</p> <p>Gratitude as strongest predictor of depression and life satisfaction; religious support directly related to gratitude</p>
McMinn et al. (2001)	Examine mental health needs and resources of Christians in Korea	<p>Quantitative – MANCOVA, <i>t</i>-tests</p> <p>Qualitative – Non-numerical Unstructured Data Indexing Searching Theorizing (NUD*IST) software</p> <p>Data: questionnaires distributed to Korean mental health professionals and pastors in Seoul, Korea; mental health needs questionnaire (quantitative, N = 79); resource assessment questionnaire (qualitative, N = 68)</p>	<p>Significant differences for various mental health disorders between males (Wilks' <math>\lambda = 0.12</math>, <math>F(10, 30) = 21.2</math>, <math>p &lt; .001</math>) and females (Wilks' <math>\lambda = 0.17</math>, <math>F(10, 52) = 26.3</math>, <math>p &lt; .001</math>); males perceived to experience less panic symptoms, less somatic symptoms, more alcohol problems, more stress problems, more likely to be abusive</p> <p>Themes for men: lack of fellowship among Christian men; men highly stressed and experience high amounts of pressure; men experience challenges due to differences</p>

			<p>between Christianity and Confucianism (egalitarian view vs. male superiority)</p> <p>Themes for women: expectation of filling service roles (barriers to personal development); women attending church while husbands do not</p> <p>Prayer as central coping resource; other coping resources: cultural values (perseverance, rectitude), family, church community</p> <p>Conclusion(s): church important to Korean Christians; suggest collaborating with pastors to enhance already existing resources</p>
M. Kim (1990)	Explore understanding of mental health and treatment of Korean American pastors; identify predictors of mental health decisions made by pastors	<p>Quantitative – chi-square, <i>t</i>-test, logistic regression</p> <p>Data: stratified systematic sampling of Korean American pastors (N = 50, all male, age 30 to 67); 8-page questionnaire and interviews</p>	<p>Pastors generally view mental illness as mental functioning deficiency due to stresses related to environmental adaptation</p> <p>Pastors more likely to utilize religious approach to mental health treatment relying upon faith and healing ministry</p> <p>Pastor's willingness to refer others to mental health services significantly related to own amount of pastoral counseling training received</p>
Rhee, Chang, & Youn (2003)	Examine (1) knowledge of child abuse of Korean American pastors, (2) how variables such as culture, demography, and theological orientation affect attitudes towards child abuse, and (3) child abuse intervention strategies preferred by pastors	<p>Quantitative – multiple regression analysis</p> <p>Data: survey with self-administering questionnaire (N = 120 sent, 87 responses); stratified systematic sampling</p>	<p>Serious lack of training on child abuse and protection issues among Korean American clergy</p> <p>English-speaking ability of clergy correlates with adequacy/inadequacy in responding to child protection issues</p> <p>Suggestion: provide training for pastors emphasizing how their status as respected community leaders can informally play a role in protecting children</p>

### Community-based Mental Health Services

It has been suggested that a partnership between faith-based organizations and community-based health centers can serve as a way to reach out to underserved populations such as the uninsured and immigrant communities (Patel et al., 2013). Thus, in addition to the faith-based aspect of mental health service delivery, a community-based approach may also aid in meeting the mental health needs of the Korean American immigrant community. The next section of the literature review focuses on community-based approaches to mental health service delivery and their relevance to this population.



Since the Community Mental Health (CMH) Act of 1963, the U.S. government has funded public and non-profit community mental health centers throughout the U.S. in order to provide community-based care for various mental health needs (for a more detailed timeline, visit [http://www.thenationalcouncil.org/wp-content/uploads/2013/02/50th-Anniversary-Timeline\\_final\\_for\\_mag.jpg](http://www.thenationalcouncil.org/wp-content/uploads/2013/02/50th-Anniversary-Timeline_final_for_mag.jpg)). However, this system of care has not adapted to accommodate the changing demographics of the U.S. population, especially when it comes to embracing fast-growing immigrant minorities. Even though studies of community-based mental health services have been conducted since the CMH Act of 1963, literature regarding mental health service delivery models for marginalized and underserved immigrant minority populations is almost non-existent, this despite the fact that their mental health needs may be far greater than those of the mainstream population (Morgan & Hutchinson, 2010).

The existing literature related to service delivery models for community mental health services mostly has to do with the deinstitutionalization of psychiatric service recipients prior to the CMH Act. Moreover, the volume of literature on this matter has diminished over the years to the point that very little current literature on the topic exists, let alone literature focusing on community-based services for immigrant minorities. Nevertheless, several community mental health service delivery models for non-specific general populations are presented below in order to glean some insights into the rationale behind community-based mental health care.

### **Models of Community Mental Health Service System**

Since the passage of the CMH Act of 1963, several different models of community mental health services have evolved (see Table 2.9). For example, in the early days of the decentralization movement in the field of psychiatry, Hammett, Bodarky, and Fink (1971) presented a model known as the *Marriage Model*, which emphasized the involvement of the

academic community in community mental health. They sought to move beyond the traditional emphasis on education and research for students and have such students play an active role in community mental health. The model sought to prepare students to provide continuity of care, enable complete care within the home community, and minimize stigmatization and rejection by the family and neighborhood (Hammett et al., 1971).

Some years later, Lefley (1975) pointed out that many community mental health centers were underutilized by the lower-income and multiethnic populations whom they were designed to serve because of the culture gap between the typically White, middle-class providers and the typical consumer of the catchment area. Consequently, the *Miami Model* (Lefley, 1975) attempted to integrate various approaches to meet the needs, expectations, and cultural uniqueness of the diversity of catchment area residents – Bahamians, Cubans, Haitians, Puerto Ricans, and US-born African Americans in the Miami area. It is impressive that the need for culturally sensitive therapeutic interventions to deal with a diverse population was recognized so early in the history of community-based mental health services, at least in that particular region of the US. It is also impressive that efforts were made at this time to build a community support system for prevention, early intervention, and aftercare in order to ensure continuity of care. Unfortunately, there is no evidence that such efforts were adapted beyond that region or extended to non-English speaking populations, nor could any follow-up literature on this model be found.

Hudson (1990) presented a secondary analysis of data from previously published mental health policy studies and archival sources and a final path analysis. Hudson identified several principle conditions for a successful community mental health service model: excellent administrators, an integrated organizational structure, rational decision-making procedures, policies friendly to comprehensive services and a sufficient number of professionals and services

to implement the policies. Unfortunately, the analysis revealed that the aforementioned factors have the greatest impact in environments with higher levels of socioeconomic development, racial homogeneity, and citizen participation in government activities. Again, this model too came short of meeting the needs of those for whom community mental health centers are designed to serve.

Other models of community mental health services are also noteworthy, though very few in number. For example, Royeen and Ramsay (2000) provided a descriptive report of a non-profit mental health service and its programs, the Way Station Community Mental Health Center. The Way Station Community Mental Health Center was a community mental health center built on the *Clubhouse Model* (related to the *Fountain House Model*) and included the areas of prevocational training, stabilization of mental illness, improvement of social skills, increase in productivity, achievement of functional independence, improvement of job skills, and receiving supported employment services, work adjustment services, and continual care.

The *Three-Communities Model* is a collaboration among researchers, community-based mental health, and HIV/AIDS patients wherein the research and practice were taking place concurrently in an interdependent approach (Reed & Collins, 1994). Another example is the *Problem-Policy-Program Model* (Barton, 1978). In order to ensure the effectiveness of community mental health services, this paradigm takes into account (1) the community's needs or problems relating to mental health services, (2) problems in policy formulation, and (3) program development from design to implementation.

Another example of an interesting paradigm for community mental health services is presented by Flannery, Adams, and O'Connor (2011), who suggested that a model for community mental health service delivery should include important elements such as integrated emergency

and inpatient care, ongoing care coordination and partnership with various community providers, and early intervention services for the young. They emphasized outreach to the community in which the program resides and seeks to serve as the key success factor for community-based mental health service.

In Table 2.10 below, various models of community-based mental health service delivery mentioned above are summarized. It should be noted that the models are services that are publicly supported at the federal and/or local levels.

Table 2.10

*Models of Community-based Mental Health Systems*

Literature	Model (period)	Practice Location	Target Population	Philosophy/Mission/Vision
Finch (1986)	Fountain House Model (1948 -)	NYC	Chronically mentally ill patients transitioning from state hospital to local communities	Chronically mental ill are regarded as “members” rather than “clients” Emphasis on member participation in various work roles (non-clinical rehabilitation).
Kellam & Sheldon (1966)	Woodlawn Community Mental Health Center Model (1962)	Chicago, IL	Psychiatric population transitioning out of inner city	Relationship between psychiatric illness and social process of the community (collaborative work with Community Advisory Board representing different religious or social community organizations)
	Miami Model (1975)/ Jackson Memorial Hospital CMHC	Miami, FL	Lower-income multiethnic population	Culturally specific therapeutic interventions and building community support system with ethnically diverse group
Royeen & Ramsay (2000)	Way Station Model (1978)	Frederick, Maryland	Individuals with mental illness	Clubhouse approach to psychiatric rehabilitative service
Leff, Dada, & Graves (1986)	LP Planning Model (1986)	Conceptual framework  No known implementation of the model, additional research recommended	Classified patients according to their functional level and service needs.	Resource planning allocation decision making tool for mental health community support system (what services to offer to whom)
Reed & Collins (1994)	Three Communities Model (hypothetical)	National level	Persons with HIV/AIDS	Collaboration among 1) researchers, 2) community-based organizations (CBOs), and 3) persons with HIV/AIDS (social

	proposed model, 1990)			psychological model of interdependence)
Takeuchi, Mokuau, & Chun (1992)	Parallel Model (2003) - South Cove Health Center	South Cove, Boston (Chinatown)	Chinese psychiatric patients	Provision of programs similar to existing mainstream programs but devoted to ethnic minority groups by achieving various types of service and or organizational matches (i.e. matching ethnicity, language preference, and case management needs)
Smith, Erlich, & Sederer (2013)	Integration Model (2012 -)	State of New York	Population being served in NYS public mental health system	Integration of general medical and behavioral health services (modern transformation of state mental health authority into an accountable and integrated health delivery system)

---

Lafollette and Pilisuk (1981) made a distinction between public community mental health centers which are developed as a result of federal and state regulation and *alternative mental health centers* that are non-profit agencies such as free clinics or ES (ethnic-group-focused) agencies born out of a response to perceived unmet needs in a particular locality. The authors delineated the hallmarks of the traditional sense of a community mental health center as “(1) multijurisdictional funding utilizing local resources in conjunction with state and federal matching grants, (2) establishment of a variety of mental health service categories appropriate for reimbursement (e.g. Medicare and Medicaid), (3) utilization of local mental health boards in providing for various degrees of citizen participation, and (4) integration of a number of planning levels - federal, state, and local - in the development of mental health programs and policies” (p. 211).

However, Lafollette and Pilisuk (1981) also postulated that alternative mental health programs are designed to meet the needs of members of people groups that do not fit into the traditional community mental health setting. They noted that alternative mental health programs tend to be pragmatic, eclectic, holistic, and oriented to a particular worldview. In that sense, the *alternative mental health services model* that the authors refer to is a viable model for ethnic-

focused, community-centered, faith-based mental health programs, and thus may be quite viable as a model for the delivery of mental health services to Korean Americans.

In order to serve populations such as Korean Americans whose needs may be served by the alternative mental health care described above, the *collaborative care model* marries mental health services with primary care. In the next section, the collaborative care model as it relates to the target population of this study is discussed in more detail.

### **Community Adaptation of the Collaborative Care Model**

One possible implementation of the collaborative care model is to integrate primary and psychiatric care in order to provide mental health services. Some noteworthy examples of community mental health services being adapted to ethnic immigrant populations exist. One such study by Yeung et al. (2004) took a 12-month long look at the *Bridge Project*, which promoted collaboration between primary care and mental health care providers for low-income Chinese immigrants. Yeung et al. sought to investigate the effectiveness of integrating primary care and mental health services as it relates to referrals and treatment acceptability. The study showed a 60% increase ( $\chi^2 = 4.97, p < .05$ ) in the number of referrals of clinic patients to mental health services by primary care physicians during the duration of the project. In addition, 88% of patients referred during the project showed up for psychiatric evaluation as compared to 53% ( $\chi^2 = 15.3, p < .001$ ) of patients who did so before the project. Therefore, integrating mental health care and primary care was found to be effective in improving access to mental health services and in increasing treatment engagement among low-income immigrant Chinese American immigrants.

Another example can be found in a study done by Kaltman et al. (2011) that investigated a specific innovative adaptation of a community mental health collaborative care model to meet

the needs of low-income, uninsured immigrants in a primary care setting in the Montgomery Cares Behavioral Health Program (MCBHP) in Montgomery County outside of the Washington, D.C. area. This collaborative care model included: (1) provision of one or more mental health or allied health professionals such as a care manager to the primary care clinic staff to offer various services including assessment, psycho-education, referral, and patient tracking, (2) consultations performed by an on-site psychiatrist offering caseload supervision and emergency help, and (3) ongoing contact and feedback among all individuals involved in patient care to be coordinated by the care manager (Kaltman et al., 2011). A network of three primary clinics was utilized to implement the collaborative care model. Patients with mental health needs were identified and evaluated to determine the level of care needed and then given appropriate treatment including medication, support, social services, psychotherapy, and psychiatric consultations.

Kaltman et al. (2011) noted that community-based mental health care in a primary care setting can mitigate mental health care disparities while also offering effective treatment for a large number of low-income, uninsured immigrant community residents. The authors indicated that the MCBHP chose to utilize the collaborative care model because of the extensive empirical support and evidence of cost efficiency. The MCBHP proved to be a successful adaptation of the evidence-based treatment model of traditional collaborative care, preserving the essential components of the collaborative care model while allowing a level of flexibility.

Such a collaborative care model is similarly expressed as an integrative model, integrating general medical and behavioral health care. For example, the state of New York implemented an integrated public health delivery system in 2012 as a collaborative effort between the state's Office of Mental Health and the Department of Health at 22 primary care training clinics (Smith, Erlich, & Sederer, 2013). Smith et al. (2013) promoted integration of

general medical and mental health care as a cost-effective evidence-based approach to providing clinical care. The authors indicated that integrated health care enables collaborative care that is timely and effective, both clinically and financially, in providing care to the whole person.

Lafollette and Pilisuk (1981) pointed out that, several decades after the initial development of community mental health centers, the model of such centers was beginning to migrate towards the “alternative mental health clinic” (p. 210). According to the authors, these alternative mental health clinics were created to meet the perceived needs of local communities, rather than resulting from federal and local legislation mandating their genesis. Table 2.11 outlines some of the key distinctions between these two models for the providing of mental health services.

Table 2.11

*Comparison between Community Mental Health Centers and Alternative Mental Health Clinics*

	Community Mental Health Centers	Alternative Mental Health Clinics
Service model	Traditional psychiatric or medical model of practice Strong quality control	Pragmatic, eclectic, holistic and client-focused Wide range of treatment modalities employed Auxiliary services related to housing and employment sometimes included Lack of quality control
Relation to local government	Close ties to governmental authority Receive federal/state financial support	No official ties to governmental authority Financially supported by individuals and private foundations
Composition and function of the board	Varied board functions depending on each state’s regulations or local conditions such as poverty Primarily hierarchical structure	Little distinction between consumers and providers of services/board members Largely run by volunteer staff
Funding	Focused on continuing support for existing programs	Mixture of largely private funding with some limited governmental funding in order to maintain program independence

Lafollette and Pilisuk (1981) also point out the departure of CMHCs from the medical model to include crisis clinics, halfway houses, and rehabilitation programs with job



training/placement, community involvement activities, and family therapy, as well as the lack of sufficient support and adequate treatment for racial minorities at many CMHCs.

### **Summary of Literature Review**

The review of the literature concerning mental health issues and service delivery models for immigrant minority populations in general and Korean Americans in particular reveals that very few studies related to these topics exist, and that practice models and actual existing programs that reflect the research findings outlined in this literature review are even scarcer. Based on a review of the available literature generated from related past inquiries, it can be said with some confidence that the gap between the mental health needs of immigrant minority populations and the services available to them gives reason for serious concern regarding the future mental health of a growing portion of the U.S. population. Some efforts have been made to reduce the mental health disparities faced by minorities. A handful of researchers have investigated possible solutions to the problem of the underutilization of services by certain minority groups, resulting in the discovery that both individual and contextual barriers impede such populations from seeking and receiving mental health services. Sincere attempts have also been made in some cases to increase cultural sensitivity in mental health services targeting minorities.

However, no concrete model has been presented that applies the understandings gained from such studies to immigrant minorities, Asian Americans, and Korean Americans in particular, who have an increased susceptibility to mental health problems. This is somewhat ironic since Korean Americans are at higher risk for mental health problems than other Asian American immigrant groups as indicated in the above literature review. Therefore, the need to

identify and develop an effective mental health service delivery model for this underserved population is critical.

### **Gap between Knowledge and Practice**

In summary, the limited literature available mainly consists of theoretical knowledge and seriously lacks connection to practical application and/or implementation, leaving a significant gap between theory and practice. Although there may not be a single formula for outlining an ideal mental health services delivery model to meet the needs of Korean American immigrant communities, it is imperative that an effective mental health service delivery system model that reflects the research findings be developed and implemented.

In this descriptive case study, knowledge gained from the literature review of past research findings is applied to understanding the Washington Christian Counseling Institute, which has helped to close the disparity gap between the mental health needs and underutilization of services of the Korean American community, thus establishing the validity and credibility of this study.

## **CHAPTER THREE: METHODS**

### **Research Design**

Research design provides a link between the data to be collected and the initial questions of a study (Yin, 2009). The initial and primary purpose of this study was to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. Therefore, by describing and investigating WCCI's programs, the ultimate purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans is achieved.

This study was introduced in Chapter One, while the literature review in Chapter Two provided empirical evidence supporting the research proposal. This chapter presents the methodological details of the study. As mentioned in the introduction, the present study employed a case study research method. A case study is an empirical in-depth study of unit(s) of a system bounded by time and place, with a real-life context (Creswell, 1998/2013; Stake, 1995; Yin, 2009).

Case study methodology has a long history in research across many disciplines (Creswell, 1998/2013). This study in particular employed a descriptive case study design that is historical and sociological in orientation (Hancock & Algozzine, 2011). A sociological approach demands investigation of the "structure, development, interaction, and collective behavior of an organized group" (Hancock & Algozzine, 2011, p. 36). Therefore, the development and structure, as well as the interactions and collaboration between programs and focus groups within WCCI, were

investigated. Because WCCI has a history stretching back to the inception of GCC (formerly known as FCSC), this study also employed a historical approach. Thus the context of the case includes the history of GCC, which is described in detail.

Finally, this study is also an “intrinsic case study” (Creswell, 1998/2013, p. 62) in that it highlights the uniqueness of WCCI’s programs in serving the particular ethnic community of Korean American immigrants. Stake (1995) explained that the primary goal of an intrinsic case study is to understand the case, which in this instance includes the mental health programs offered by WCCI.

### **Selection of Participants**

Participants were purposefully selected in order to best gain information pertinent to the particular research questions (Kazdin, 2002). In terms of the selection criteria, the participants included founders of WCCI as well as WCCI program service providers and service recipients (see Tables 3.1, 3.2, and 3.3 below for a detailed list of the participants and the questions that are explored with each of them). The participants were selected from each of the program areas and focus groups, i.e. Friends of WCCI, the WCCI Youth Council, and the WCCI Professional Forum. The rationale for such a sampling strategy is to achieve maximum variation in data and to gain various perspectives (Creswell, 2003). Because this study is descriptive in nature, the founders of the organization, Dr. and Mrs. T. S. Park, were interviewed as they are and have been the gatekeepers of WCCI throughout the lifetime of the organization. Through them, the researcher had access to records and other historical data and gained access to other interviewees and programs, as represented in Figure 3.1 below. The research setting was on-site at the GCC location in which WCCI is housed. Upon agreeing to take part in this study, participants were

informed of the particulars of the study and were asked to express their agreement with the terms and conditions of their participation in the study by signing a consent form.

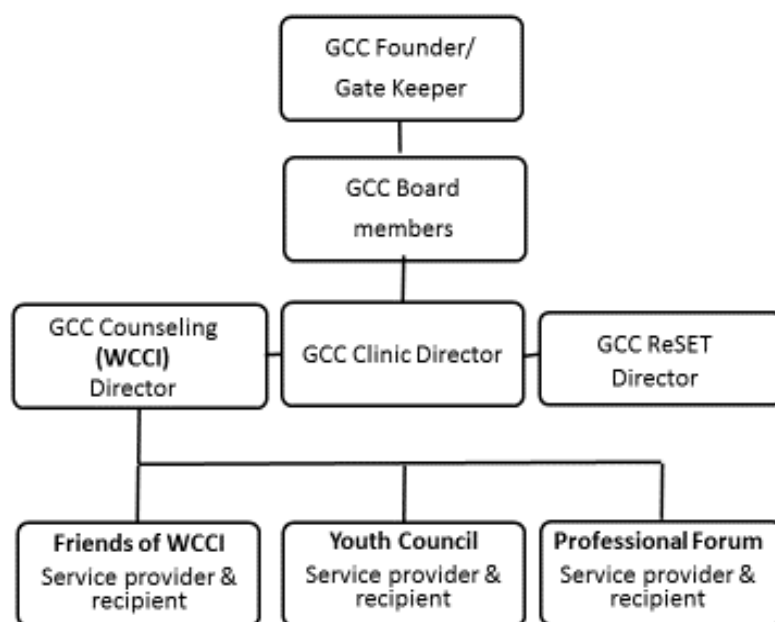


Figure 3.1. Selection of Participants

Table 3.1

*Selected Participants: Organizational Leadership*

Program	Interviewee	Research Questions
Grace Community Service Center	Founder	How does the organization (service system) function - financing (fundraising and allocation), staffing, decision making, and providing services? What partnerships exist within the system (GCC) and with outside organizations and/or individuals? How are such partnerships established and maintained, and how do they function? What are the shared goals and objectives of the different service areas within GCC?
Grace Community Service Center Board	Board members	What is the structure of the board? What selection criteria are used to select board members? What are the terms of service for the board members? What is the role of the board? What are the responsibilities of the board?
GCC Health Clinic	Director	What programs/services are offered? What constructs are unique to the health clinic programs?

		What kinds of partnerships exist with other programs/services? How do those partnerships work? How are the clinic's operations funded? Describe the clinic's dual focus on serving Korean Americans and Non-Korean immigrant communities.
GCC Bridges (ReSET)	Director	What programs/services are offered? What constructs are unique to the ReSET program? What kinds of partnerships exist with other programs/services? How do those partnership work? How is the program funded?
GCC Counseling	Director	What programs/services are offered? What constructs are unique to WCCI's programs? What kinds of partnerships exist with other programs/services? How do those partnerships work? How are WCCI's programs funded?

Table 3.2

*Selected Participants: Program Service Providers*

Programs	Interviewee	Research Questions
Friends of WCCI	S. P.	How are the programs formed and structured? What are the goals and objectives of the programs? Who is involved, including both providers and recipients? How are partnerships with other programs established and maintained, and how do they function? How do the programs work and what factors influence their success? What is the motivation for individuals to volunteer/serve in this way?
WCCI Youth Council	K. K.	How are the programs formed and structured? What are the goals and objectives of the programs? Who is involved, including both providers and recipients? How are partnerships with other programs established and maintained, and how do they function? How do the programs work and what factors influence their success? What is the motivation for individuals to volunteer/serve in this way?
WCCI Professional forum	J. S. K.	How are the programs formed and structured? What are the goals and objectives of the programs? Who is involved, including both providers and recipients? How are partnerships with other programs established and maintained, and how do they function? How do the programs work and what factors influence their success? What is the motivation for individuals to volunteer/serve in this way?

Table 3.3

*Selected Interviewees: Program Service Recipients*

Programs	Interviewee	Research Questions
Friends of WCCI	Y. M. K.	What are individual's goals and objectives for participation in this program? What are the benefits experienced by those participating in this program? What are the responses of those involved? How does this program benefit from its partnership/collaboration with the WCCI Youth Council and/or WCCI Professional Forum?

		What specific activities are planned and/or conducted by this program? What do the recipients gain from this program?
WCCI Youth Council	M. C.	What are individual's goals and objectives for participation in this program? What are the benefits experienced by those participating in this program? What are the responses of those involved? How does this program benefit from its partnership/collaboration with Friends of WCCI and/or the WCCI Professional Forum? What specific activities are planned and/or conducted by this program? What do the recipients gain from this program?
WCCI Professional Forum	P. M.	What are individual's goals and objectives for participation in this program? What are the benefits experienced by those participating in this program? What are the responses of those involved? How does this program benefit from its partnership/collaboration with Friends of WCCI and/or the WCCI Youth Council? What specific activities are planned and/or conducted by this program? What do the recipients gain from the program?

### **Data Collection and Procedures**

The data was collected from multiple sources. Creswell (2003) lists four basic methods of data collection for qualitative research: observations, interviews, documents, and audiovisual materials. This study employed three of the four methods (observations, interviews, and documents), with such information being collected from various sources. First, interviews with the key players of the programs were conducted in a semi-structured format. This included both providers and recipients of WCCI programs as well as the administrative and leadership staff. Second, archived documents were reviewed, including emails and other forms of communications over the course of the development of the organization. Third, in-field observations of the programs and meetings of the various focus groups (e.g. Friends of WCCI, WCCI Professional Forum, and the WCCI Youth Council) were conducted and recorded.

The data collected highlighted the important programs and the processes by which the programs operate. The data also provided information on the relationships between the various programs and their key players, highlighting the integrative and collaborative aspects of the organization and its programs. In this way, the distinctive characteristics of the WCCI system

were identified. The data collection process used via interview, observation, and document review is further explained later in the study.

## **Interviews**

Interviews are an essential source of information in case studies (Yin, 2009). The researcher conducted semi-structured and in-depth face-to-face interviews with selected participants using the questions listed in Table 3.1, 3.2 or 3.3 depending on the participant being interviewed. The interviews were audio-recorded and transcribed. The interviews were semi-structured in that they included both predetermined questions and follow-up questions asked to obtain further information. The dates, times, participants present, and locations at which the interviews were conducted were determined according to the convenience of the participants at the on-site location.

Prior to the interviews, the interviewees were briefed on the purpose of the interview, the length of time required, and the expected date for written report of the interview for their review. They were also provided with confidentiality information, and their consent was obtained via a consent form upon their agreement (see Consent Form Appendix D). In addition, the researcher informed each participant of his or her right to end the interview at any time during the interview if/when the participant felt uncomfortable and desired to stop the process. Finally, upon completion of each interview, the researcher inquired with the interviewee to ensure that the interview did not create any psychological distress.

It should be noted that the interviews were conducted in a bilingual fashion. Although the primary mode of communication was English, the use of the Korean language was permitted in order to allow both the interviewer and interviewee to elaborate upon, explain, or clarify content



as needed in order to overcome any communication limitations due to limits in an interviewee's English proficiency.

Data collection by way of interview has its own limitations. People have different levels of articulation and perceptiveness, and thus the quality of the content that different interviews produce may vary (Creswell, 2003). Yin (2009) points out that interviewee bias, poor recall, and poor articulation can be problems as well. Nonetheless, information drawn from different perspectives is still valuable and can be a strength of such a method. Specifically, the advantages of using interviews to collect data include the interviewer's being able to lead a line of questioning, obtain related historical information, and to pose open-ended questions that can illicit views and opinions from the participants (Creswell, 2003).

### **Observations**

In-field observations were conducted in order to collect data. Observation is an appropriate and effective method for collecting data because it provides relevant behavioral or environmental information for the case (Yin, 2009). The researcher attended focus group meetings and took notes in a discrete manner in order to record the five Ws (who, when, what, why, and how) and then summarized the notes for data analysis. WCCI's three focus groups – Friends of WCCI, the WCCI Professional Forum, and the WCCI Youth Council – were observed during their regular meetings and special events. Interactions and relational dynamics among the members were observed for content and any notable characteristics and patterns. The date, time, participants present, and location at which the observations took place was determined in collaboration with the potential participants. Prior to the observation, the researcher briefed the participants and explained why, how, and for whom the observations were made.

Every participant present at an observation was provided with confidentiality information and their consent was obtained via a consent form upon their agreement. Any questions or concerns that a participant may have had were addressed at that time. The purpose of the observation, the length of time required, and the expected completion date of the written report of the observation for review by the participant(s) were explained. In addition, the researcher informed the participants of their right to excuse themselves from the observation if and when they felt uncomfortable and desired to stop the process. Finally, upon completion of each observation, the researcher inquired with the participants to ensure that the observation did not create any psychological distress.

Even though the method of in-field observation has its limitations (e.g., the researcher may be seen as intrusive, or certain information may be too personal to report), the strengths of this method far outweigh the possible weaknesses. For example, the researcher can record information as it unfolds and non-verbal aspects of communication and self-disclosure can be witnessed during observations (Creswell, 2003). Also, the information gleaned from a direct observation provide vivid context to the case being studied as the case study takes place in the natural setting of the case (Yin, 2009).

### **Document Reviews**

In addition to in-person interviews and observations, additional information was gathered by reviewing relevant available documents. According to Yin (2009), the documentary information can include: (a) letters, memorandums, correspondence, and other personal or internal documents; (2) announcements, meeting minutes and other written reports of relevant events; (3) administrative documents such as proposals and reports; and (4) news clippings and articles printed in mass media. Therefore, the different categories of documents that were

reviewed for data collection included private and public records relating to the formation of WCCI as well as a review of survey results collected over the years from various WCCI-run programs. Private records included email correspondences between staff during the program development and public records included official documents filed with or submitted to the local government and other public agencies.

Beginning with public records related to the initial formation of WCCI as a 501(c)(3) charity organization, archived documents including meeting minutes, activity records, internal correspondence, grant proposals and awards, fundraising event results, and website content were reviewed. The researcher also reviewed written feedback on programs offered by WCCI. Such information enhanced the researcher's ability to answer the research question as to how WCCI programs are meeting the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area.

All of the data collection described above aided in fleshing out the details of the unique approach taken in the service delivery model developed by WCCI. It should be noted that the document review process involved a very significant challenge in that GCC and WCCI and their programs have evolved informally and without systematic planning, and thus lacked official records in many cases. Nonetheless, reviewing the available documents did provide evidence to verify and support the data collected via other methods in addition to it being an "unobtrusive source of information" (Creswell, 2003, p. 187). The strength of documentation review method is also supported by Yin (2009) who notes that use of documents corroborates and augments evidence gained via other aforementioned sources of information.

In summary, data collection was accomplished by interviewing the organization's founders, service providers, and service recipients, observing focus group meetings and

activities, and reviewing available documents that provide the organizational history and development of the programs at WCCI. Collected data, including identifiable private information, were compiled and stored securely in the researcher's personal desktop computer with a password lock and only the researcher had access to the research records. The researcher also ensured the privacy and confidentiality of the participants by disposing of any individual identifiable data at the conclusion of this study, limiting future use of the data to de-identified data only. Procedures that have been followed include: (a) the obtaining of approval for the study from the Institutional Review Board (IRB), (b) the informing of participants of the intent for the study and all relevant details of the study so as to obtain their consent and cooperation, (c) the collection of data through the various aforementioned means, and (d) the review and checking of the data collected for accuracy and consistency. Therefore, via the aforementioned various means of data collection, an in-depth and detailed description of the case (WCCI programs) emerged.

### **Data Analysis and Synthesis**

Data analysis essentially means taking apart the data collected and is as much an art and intuitive process as it is based on systematic protocols used to search for meaning (Stake, 1995). The following consists of a brief, general outline of the data analysis and synthesis methods that were used to organize and analyze the data collected. This data analysis and synthesis result in an in-depth and detailed description of various aspects of the present case.

First, in order to prepare the data for analysis, the data was organized by different categories (i.e., programs) of information, proceeded by transcribed interviews and a summary of the field notes and reviewed documents collected. Second, in order to conduct the analysis, a holistic analysis of the entire case (i.e., all of the WCCI programs) and naturalistic

generalizations were made (Creswell, 1998/2013). Creswell (2003) defines a naturalistic generalization as a generalization that can be drawn from a case analysis; it can be made for its own sake or applied to a case population. In this case, the naturalistic generalizations produced by this study's population can be applied to any ethnic immigrant community with similar needs. Third, to represent the data in a qualitative narrative along with tables and figures, a detailed description of the case (WCCI) within a broader context/setting (GCC) have been laid out. Hallmarks for each phase in the development of WCCI's programs were also provided. Lastly, the larger meaning of the data (i.e., lessons learned) was explored in order to draw conclusions as to the characteristics needed to create a viable model by which to deliver ethnic-specific, community-centered, faith-based services to meet the mental health needs of immigrant minority communities.

In summary, the data analysis entailed units of analysis being organized by categories, holistic analysis being applied to linking data, and the creation of a qualitative narrative. Finally, the data analysis converged to present the lessons learned from this particular case (WCCI programs), and some general applicability of the findings asserted. It is important to note that the case analysis does not cover any aspects of evaluation. Rather, it is limited to describing and understanding the case.

## **Validity and Reliability**

### **Validity**

Validity refers to the conceptual and scientific soundness of a research study (Marczyk, DeMatteo, & Festinger, 2005). Therefore, in order to draw valid inferences from the data analysis, external validity, construct validity, internal validity have been considered. First,

external validity was considered in the research design of the case study. External validity addresses to what extent the research findings can be generalized (Kazdin, 2002). In this study, one of the limitations may be related to the characteristics of the case in that the organization and programs are specifically targeted toward the Korean American immigrant community in the Washington, D.C. metropolitan area. Thus, the generalizability of the findings may be limited to communities of similar nature, such as ethnic minorities, Asian Americans, and/or the Korean American community in areas with a high population density.

Second, construct validity was considered during the data collection phase. Construct validity addresses what conceptual basis underlies the effects (Kazdin, 2002). By employing multiple sources of data such as interviews, observations, and document reviews, the construct validity is ensured. Trustworthiness, credibility, confirmability, and data dependability are also strengthened. These aspects were further enhanced by having the research participants (interviewees) review drafts of the transcribed interview reports as well as the case study report. Third, internal validity was considered during the data analysis. Internal validity addresses to what extent the WCCI and its programs can account for meeting the mental health needs of the Korean American immigrant community. Findings from interviews, observations, and reviews of records yielded certain themes, patterns, or other data trends and thus validate, credit, and/or allow one to safely infer the significance of WCCI and its programs as well as its unique approach. In addition, rival explanations were addressed when possible to further strengthen the internal validity of the study.

### **Reliability**

Reliability in a case study demonstrates that the operation of a study can be repeated and result in the same findings. Yin (2009) recommends that researchers approach the reliability

problem by making as many steps of the research process as clear and repeatable as possible. Therefore, by clearly documenting the protocols used for conducting interviews, observations, and record reviews during data collection, the reliability of the present case study was ensured. In addition, the researcher developed and preserved a comprehensive database in order to strengthen the reliability of this study.

### **Ethical Considerations and Limitations**

Most research studies with human participants involve some degree of risk, ranging from causing minor discomfort to more significant stress, to affecting the emotional well-being of the study participants. Thus, ethical dilemmas are presented regarding the degree to which participants are placed at risk for the purpose of scientific inquiry (Marczyk et al., 2005). In this present study, the level of risk for harm was no more than minimal. Nonetheless, in order to ensure ethical conduct of the researcher and to safeguard the well-being of the participants, the previously discussed measures were taken during the data collection process. Permissions were obtained to interview, observe, and to access records, and consents were gathered from participants via consent forms. Participants were also provided with a one-page research summary which included the purpose of and rationale for the current study. They were assured of the confidentiality of the interview process and data collection. Finally, the researcher also took special care during observation to be unobtrusive (Stake, 1995).

Another area of ethical consideration involved the researcher's personal interest and potential biases related to the present case study. Hancock and Algozzine (2011) warn researchers against possible biases and predispositions with regard to case studies, and thus the potential for prejudice in research activities and the interpretation of a study's findings. Creswell

(1998/2013) also cautions about case studies involving sites or people with whom the researcher has an intimate knowledge or vested interest. According to Creswell, in these types of case studies, the researcher's own values and biases towards the research project can cause the value of the data to be compromised, due to the researcher possibly withholding or skewing information for political reasons.

Therefore, the researcher is cognizant of her personal role as a volunteer within the organization and the risk of being less than completely objective and thus the study possibly being presented more positively than deserved. The researcher is also cognizant of the case study being limited by the participants for interviews and observations in that they are voluntarily involved with WCCI and may also be biased positively toward WCCI.

Despite these potential limitations, understanding the workings of WCCI is determined to be hugely beneficial, especially for communities with characteristics similar to that of the area and population served by WCCI. Therefore, taking a closer look at WCCI and its unique programs is still a worthy endeavor. To ensure proper objectivity throughout the research process, a personal reflective journal is kept by the researcher and ongoing consultation is obtained from the various professional mentors who had the knowledge of the study being conducted. It should also be noted that neither the researcher nor any of the participants are in any circumstance where personal, professional, or financial gain is possible as a result of this study.

### **Summary**

In this chapter, the methodological details of this study have been presented. The purposeful selection of participants was explained and the proposed research questions were



listed. Three sources of data collection (interviews, observations, and documents) and the procedures used with them were then explained as well as the plan for data analysis and synthesis. In addition, the special issues of validity and reliability, as they pertain to this case study, were addressed. Finally, some ethical considerations were discussed along with the limitations of the study.

Given that the study was introduced in Chapter One, the literature review was presented in Chapter Two, and the methodological details of the study were explained in this Chapter Three, what follows is a comprehensive summary of this case study research. This study conducted a case study of the ethnically-tailored, community-centered, and faith-based mental health programs offered by WCCI. It investigated and described the innovative approach taken by WCCI to meet the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. The importance of this study is compelling in that there is a clear gap between knowledge and practice with regard to the prevalence of mental health problems among immigrant ethnic minority populations as well as the disparity in the availability and utilization of services available to such populations. The lack of a viable service delivery model that could be used to meet the needs of Korean American immigrant communities is particularly significant given that Korean Americans, being the most recent immigrant group among Asian Americans, suffer higher levels of stresses due to language and cultural barriers and thus are at a higher risk of suffering from mental health issues as compared to other Asian American populations.

The issue of the unmet or underserved mental health needs of the Korean American community has been presented in the introduction. The importance of meeting those needs by providing culturally informed and linguistically compatible services tailored to the unique needs

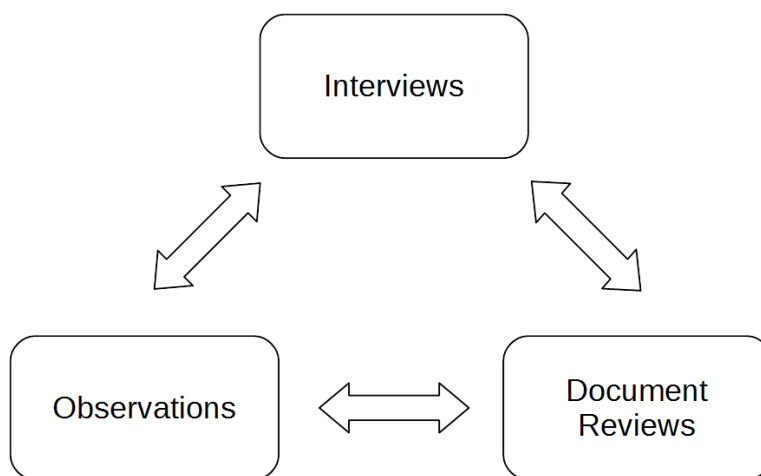
of the Korean American immigrant community was and continues to be the rationale for this present study. This study also has broader significance in that it can provide a model to aid other immigrant communities of similar cultures in meeting the mental health needs of their people, especially for communities where mainstream mental health services are significantly underutilized due to language and cultural issues.

In conclusion, this case study which investigated and described WCCI's programs is an important undertaking that can provide a viable mental health service delivery model not only for the growing mental health needs of Korean American immigrant communities but also for other immigrant minority communities of similar culture.

## CHAPTER FOUR: RESULTS

### Introduction

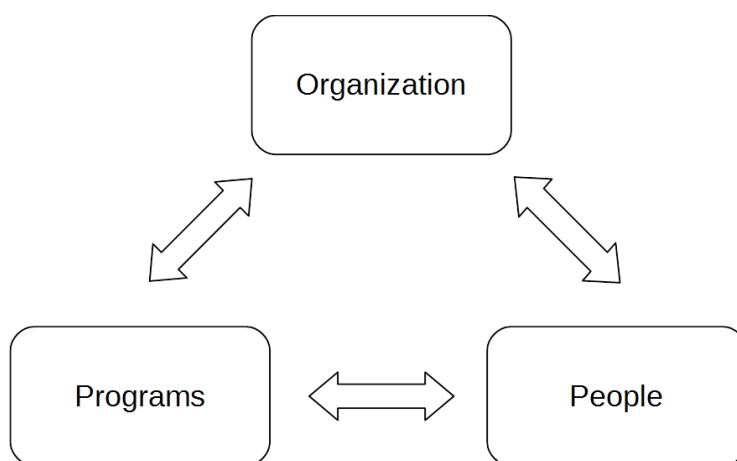
The results of the data collection and analysis are presented in this chapter. As illustrated in Figure 4.1, data collection was performed through methodological triangulation using three different sources (i.e., observations, interviews, and record reviews). The assumption underlying this methodological approach is that if the data sets obtained via the three different instruments support each other, this increases the validity of the study (Yin, 2009). O'Donoghue and Punch (2003) defined triangulation as a way of cross-checking data from multiple sources to measure the same object of interest. For example, the data collected from interviews about WCCI programs were also verified through reviewing the available documents (e.g. email correspondence, public announcements, etc.), as well as the observation of the actual programming.



*Figure 4.1.* Methodological Triangulation in Data Collection

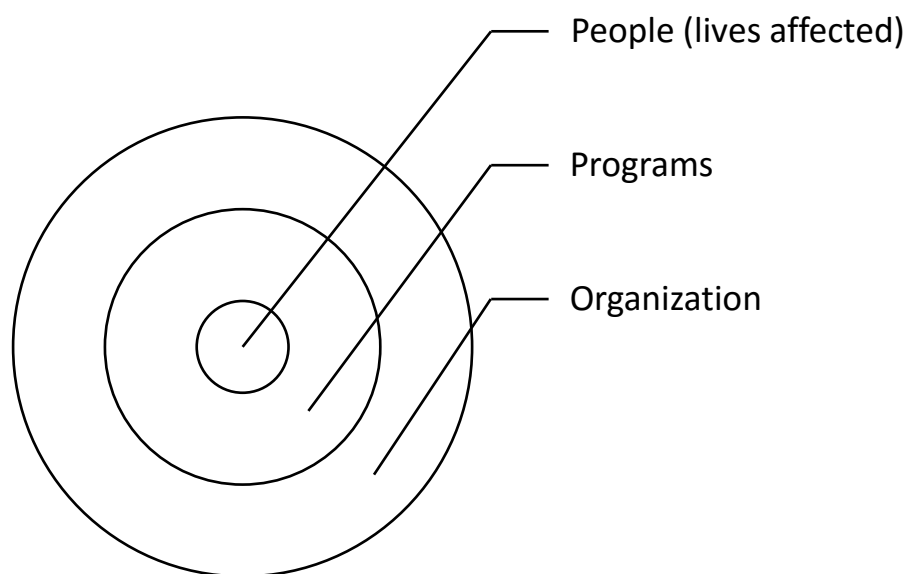
Interviews were conducted with key informants to obtain information regarding the workings of the organization and their perceptions of the organization and its work. Included within the group of key informants representing various components of the organization and programs are the founder of the umbrella organization Grace Community Center, its board members, the directors of each sub-organization (including the executive director of WCCI), and several service providers and program recipients. Observations of activities were made to illuminate how integration and collaboration between various levels of the organization and its programs were expressed. Documents such as archived reports, grant proposals, meeting minutes, PowerPoint presentations, and email correspondence were reviewed to understand and describe how the organization and its programs have evolved.

The data analysis also reflects data triangulation by using the same three instruments (observations, interviews, and record reviews) to clarify and verify which concepts/elements of the case are consistent across the different units of analysis. As visualized in Figure 4.2, the different units of analysis in this case study are the organization, the programs, and the people involved.



*Figure 4.2. Data Triangulation in Data Analysis*

The multiple units of analysis present a challenge owing to the diversity and the quantity of data collected (Leech & Onwuegbuzie, 2007). Analyzing the multiple units in this case, including the organization, programs, and the people, including service providers and recipients in various aspects, was indeed a massive undertaking.



*Figure 4.3. Multiple Units of Analysis*

Despite these challenges, triangulating both the data collection and analysis processes helped to create a full picture of the case, a system with many subsystems. This also served to strengthen the depth and breadth of the study findings in order to describe WCCI's ethnically-tailored, faith-based, and community-centered programs. In order to understand the multiple units of analysis and complete a holistic analysis of the case to be woven into the entire case description, a tool known as a logic model is used. The logic model is introduced and more fully explained in the following section.

## **Data Collection and Analysis Procedure**

### **Data Collection**

The data collection process began with the development of several research questions. Although the research questions were posed to the interviewees, they were also used to guide in the collecting of information relevant to the line of inquiry, and thus maintain the focus of the data collection as it proceeded. The data collection process became recursive in that the initial data collection on the organization and its programs and subsequent interactions with the collected data (examination and interpretation) provided further guidance on refining the research questions for the subsequent interviews with the people (i.e. service providers and recipients) who interact with the organization and its programs.

The data collected through interviews, observations, and document reviews has been organized by categories. In the section that follows, the data is presented according to the following three categories: the organization, the programs, and the people. The three categories of data is presented in a progressive manner. First, information about the organization is presented, followed by a presentation of the organization's programs. Finally, the reflections of the people regarding how they experienced the organization and its programs are explored. Within each of these broad categories, the data is further labeled and sorted into more specific categories within a range of topics. In addition, certain qualitative elements such as the aspect of integration and collaboration between the various systems and subsystems of the organization and its programs are identified and further described and analyzed.

### **Data Analysis and Logic Model**

The focus of the data analysis of this case study is on a single case (WCCI) which contains embedded units of analysis (programs and different groups of people). The general

analytic strategy employed here is to develop a case description. Therefore, a logic model is chosen because it is suitable for demonstrating the connections between the interdependent parts (sub-systems) that make up the whole organization (Yin, 2009).

Several web-based online resources were relied upon for guidance to understand and use the logic model including the University of Kansas work group for Community Health and Development (<http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main>), the University of Wisconsin-Extension Program Development and Evaluation Unit (<http://www.uwex.edu/ces/pdande/evaluation/pdf/lmguidcomplete.pdf>), the W.K. Kellogg Foundation (<https://www.wkkf.org/resource-directory/resource/2010/w-k-kellogg-foundation-evaluation-handbook>) and the Center for Disease Control and Prevention (<http://www.cdc.gov/healthyyouth/tutorials/logicmodel/page003.htm>).

A logic model is an overview tool/framework (Yin, 2009). It is a systematic and visual way of illustrating the relationships among resources, activities utilizing those resources, and the expected outcome. According to Yin (2009), the logic model “stipulates a complex chain of events over an extended period of time” (p. 149). It is used here as an analytical tool as well as a communication tool to describe the case and the causal relationship between the units of analysis. In other words, even though the logic model is typically used for program planning, management, evaluation, and reporting (Taylor-Powell & Henert, 2008; Wisconsin-Extension, 2003), it is not used as a framework for measurement or evaluation in this case study. Rather, it is utilized as a conceptual framework in order to identify the resources, programs/activities, and outcomes and to provide a picture of the organization and its programs. Even though slight variations exist in the terms used by different authors with regard to the different logic models

they created for their particular organizations or programs, the terms most commonly used with regard to logic models are generally consistent with the diagram and text.

Figure 4.4 illustrates a basic logic model while Figure 4.5 illustrates the logic model as applied in this case study with content details. As noted in Figure 4.4, the basic logic model has inputs, outputs, and outcomes (Taylor-Powell & Henert, 2008; Wisconsin-Extension, 2003).

First, the inputs represent the resources invested such as volunteers, funding, facilities, equipment, other organizations, and community resources. Second, the outputs represent what is being done with the inputs and may include processes, actions, techniques, and events that are part of the program implementation as well as the number of clients served, volunteers trained, classes held, services delivered, activities hosted, and the amount of participation generated through the investment of resources. Finally, outcomes are distinguished from outputs in that the outcomes represent the benefits and impact resulting from the outputs.

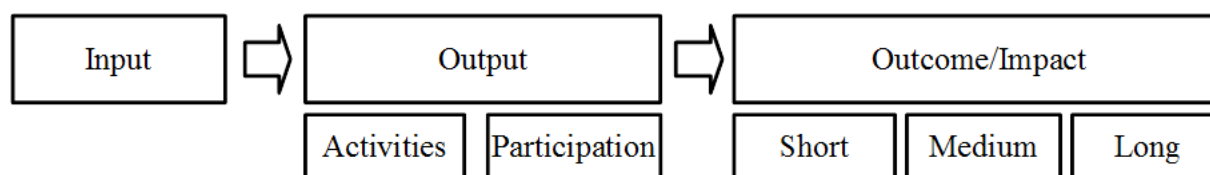
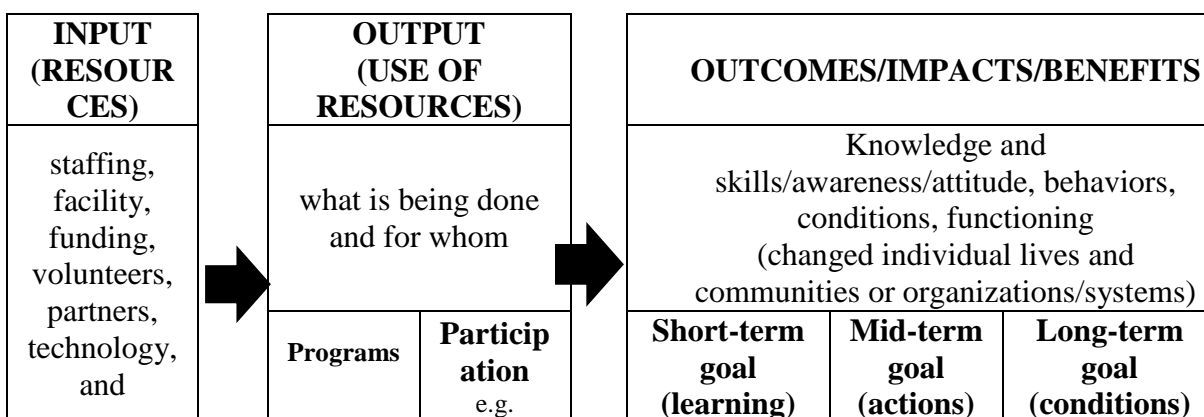


Figure 4.4. Basic Logic Model





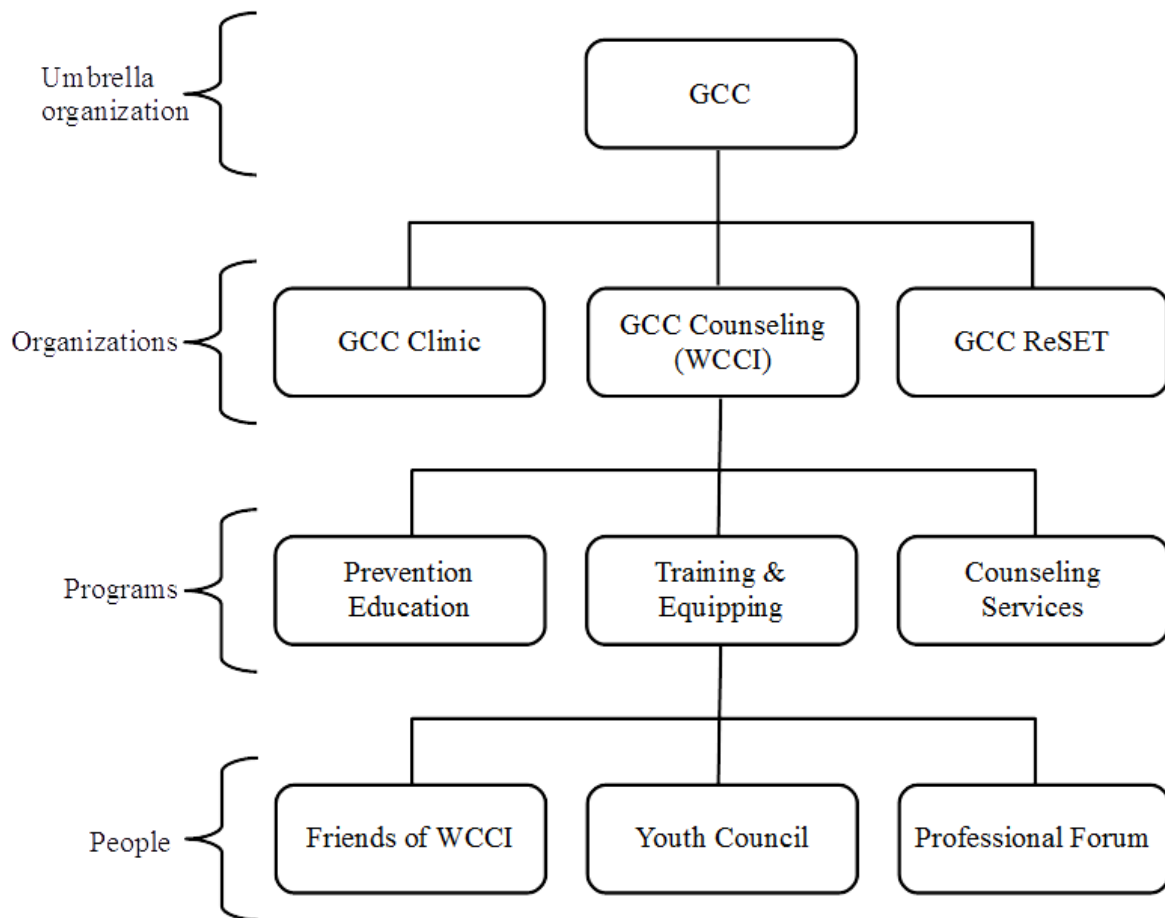
equipment/ supplies	e.g. seminars workshops training counseling and other activities	number of classes, sessions, clients, staff & volunteers in the activity	awareness; skills; knowledge; attitudes; opinions	behavior; decision- making; policies; practice	social, economical, civic, environmental changes
<b>What is invested</b>	<b>What is being done</b>	<b>Who partici- pates</b>	<b>Results</b>		
<b>Assumptions:</b> an ethnically-tailored, community-centered, faith-based service delivery model is an innovative approach and viable option for meeting the mental health needs of the Korean American immigrant community			<b>External factors:</b> Korean American immigrant community in D.C. area; the culture, individual backgrounds, and experience of program participants; and other external factors that influence program implementation/adaptation		

*Figure 4.5. Logic Model (content detail)*

In this case study, the outcome indicators can be illustrated using the descriptions given by the people involved with the inputs and outputs because the evaluation resides within the qualitative feedback of the program administrators and recipients (Taylor-Powell & Henert, 2008). In the foregoing, the logic model is applied to and used to illuminate various levels of organizational system and sub-systems.

### **Description of Grace Community Center (GCC)**

Although the Washington Christian Counseling Center (WCCI) is the primary focus of this case study, it can be seen from Figure 4.6 below that WCCI operates under the umbrella organization GCC. Therefore, the initial unit of analysis is GCC. In this section, the following is described: the birth, mission, structure, and evolution of GCC, followed by an illustration of a system-level logic model applied to GCC. Thereafter, the brief descriptions of each branch (sub-system) are described, beginning with the umbrella organization GCC.



*Figure 4.6. Organization as a Case Study*

### **Birth of the Organization**

GCC, formerly known as Faith Community Service Center (FCSC), is a broad health and mental health system that promotes physical, psychological and social wellbeing. Within the GCC umbrella system, there are three sub-systems which are the three branches of GCC – a free medical clinic, WCCI, and ReSET. As a physician and elder in a Korean American immigrant

church, GCC founder Dr. T. S. Park had been offering free medical services informally at the church on Sunday afternoons for many years. In founding GCC, he formalized and increased the scope of his efforts to include providing services to the greater community outside of the church as well.

GCC was officially established as a nonprofit charitable organization in 2003. The official founding of GCC was preceded by a long period of informal prayer gatherings and brainstorming by several Christian Korean American mental health professionals and other like-minded individuals seeking ways to reach out to the underserved, those in need of but unable to access professional mental health services due to language and cultural barriers and/or lack of resources. These informal efforts over two years from 2001 to 2003 eventually gained momentum and produced a concrete result in the establishment of the Faith Community Service Center as a 501(c)(3) organization at its first location in Vienna, Virginia. Ten years later in 2013, the organization moved to its current location in Centreville, Virginia, at which time the name was officially changed to Grace Community Center (refer to the document issued by Virginia's State Corporation Commission on September 2013).

### **Organizational Vision and Mission**

According to the initial document outlining the organization and its programs, GCC's official vision/mission is expressed as follows:

Grace Community Center is a non-profit charitable organization established to serve the underserved in the greater Washington D.C. area community by centralizing financial and human resources from many local Korean American immigrant churches. It is a collaborative ministry under Christian faith that seeks to maximize limited resources and utilize the synergistic effect of unified minds and hearts within the Korean American

community in the area. Ultimately, the unity of God's people will be exemplified and His name will be honored (FCSC, 2002).

In describing how the GCC system and its three main sub-systems work, GCC board chairman W. Kim explains that for each branch, "Our mission is the same, which is to serve those in need, but each branch is committed to different works."

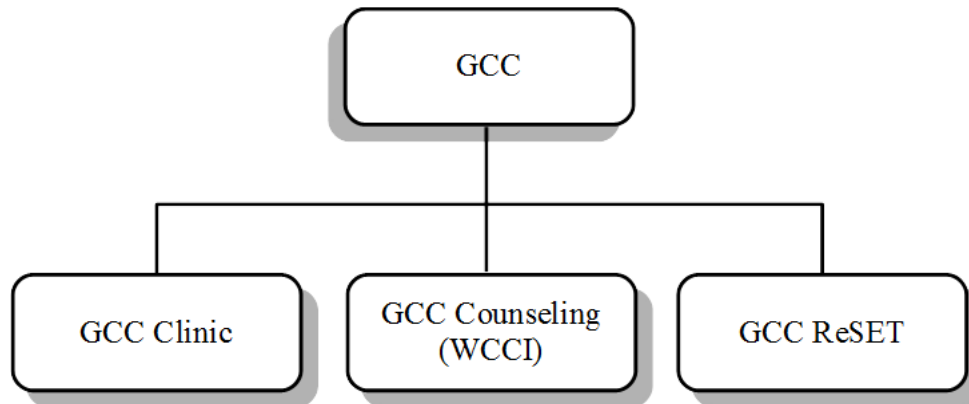
### **Evolution of the Organization**

Over the first 10 years of GCC's existence, structural changes took place which led to the development of the current form of the organization. As GCC evolved, it enlarged its scope and the focus of its work both internally to serve the Korean American immigrant community and externally to engage and serve other ethnic minority immigrant communities in the area. For example, while continuing to provide medical services to the Korean American community within the church setting, GCC's free medical clinic also provides such services to other ethnic minority communities at GCC's official location, an expansion made possible by the fact that the provision of physical care is not as heavily language-bounded as is the provision of mental health services.

At the same time, WCCI (the mental health arm of GCC) has expanded as well, particularly within the past seven years. However, its service recipients remain primarily Korean American who need Korean speaking providers owing to their difficulty in accessing mainstream mental health services due to language and cultural barriers. GCC ReSET (Rehabilitation Support, Education and Training), which promotes the social re-integration of women going through major life transitions, also grew from an informal self-contained gathering into a formalized service incorporated into the GCC system. Each of these three areas are explained in more detail below.

### Structure of the Organization

GCC is a single broad system which includes three sub-systems: the GCC Clinic, GCC Counseling (WCCI) and GCC ReSET. Figure 4.7 below illustrates the umbrella organization, GCC, and its sub-systems (referred to as branches) and Table 4.1, presented later in this section, provides the summary of the each branch.



*Figure 4.7. Basic Organizational Structure of GCC*

Figure 4.8 below places GCC and its three branches within the framework of a logic model at a broad, single-system level. In this system-level logic model, the inputs are the resources of GCC, the outputs are the activities of the three branches and their participants, and the outcomes are the impact and benefits experienced by the people involved.

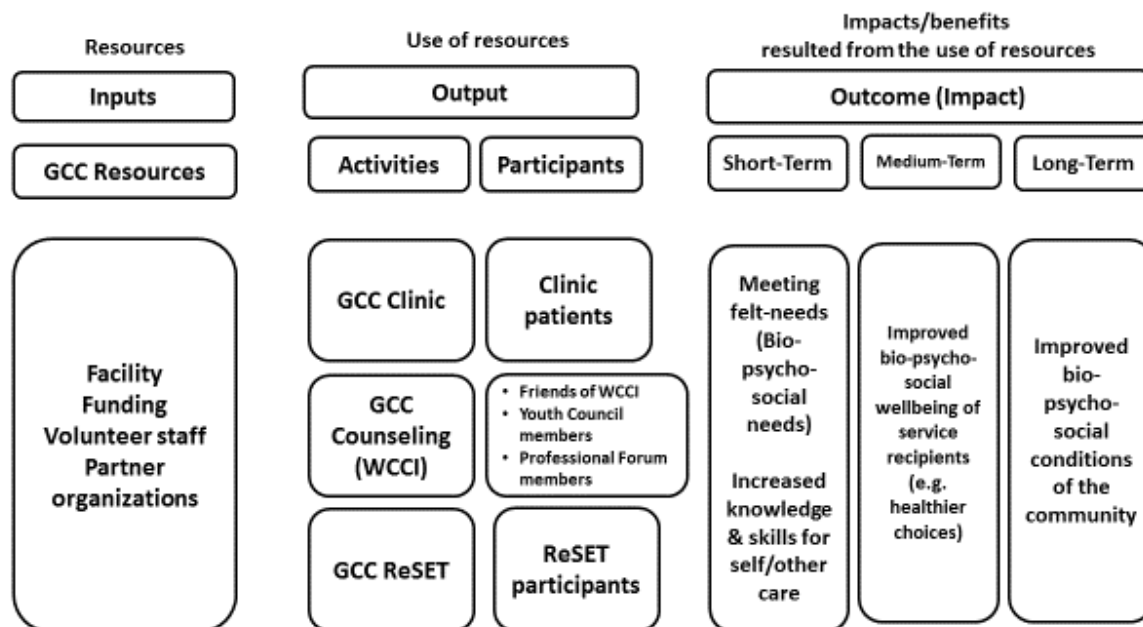


Figure 4.8. Logic Model Applied on a Single Broad System Level (GCC)

So as to provide the fuller context of GCC, each branch is briefly described and its contribution to the holistic bio-psycho-social care of the organization's program recipients explained. It should be noted that the approaches taken by all of the branches are faith-based; thus the spiritual part of the holistic care is integrated into all branches.

By and large, the inputs of GCC and WCCI are shared resources (i.e. investments). For example, the facility and other physical resources are shared by all three branches of GCC, including WCCI. However, the service providers and some of the service recipients are unique to each branch. In addition, funding and expenditures are to a large extent managed by each branch separately with freedom given to each branch's discretion, although all expenditures are ultimately reported to and are under the purview of the GCC board. Further attention will be

given to the resources (inputs) under the section of this case study focusing on WCCI, its programs, and participants.

At this point, the three branches of GCC (i.e. the outputs of GCC), are briefly described in order to set the context for the main discussion of WCCI. As pointed out earlier in applying the logic model, these three branches (areas of services) are the outputs (i.e. programs and participants) of GCC that lead to the outcome/benefit of holistic wellness, i.e. an improvement of the bio-psycho-social condition of the participants. The term bio-psycho-social is used because each branch seeks to address the needs of program participants in a different aspect – the medical clinic for physical health, WCCI for psychological health, and ReSET for social integration and health. It is again emphasized that all of the aforementioned efforts are made with spiritual health in mind as the faith-based aspect of the GCC service delivery model indicates.

**GCC Clinic (free medical clinic).** As described earlier, free medical services have been offered for many years in a church setting by Dr. Park, a physician at Fairfax Hospital. The GCC clinic was officially launched to serve other ethnic immigrant communities at the current GCC location on October 20, 2013. Initially, mostly non-Korean speaking patients were served at the GCC clinic, mainly due to Korean-speaking patients still being served at the church location. However, soon thereafter, a mobile clinic was deployed from GCC to the church on Sunday afternoons, replacing the many years of informal medical services mentioned above.

At the GCC clinic, many volunteer doctors, nurses, and pharmacists, along with the help of healthcare networkers, provide medical care to those who are without medical insurance or have little financial means. Dr. Park reports that the number of patients at the clinic has steadily increased since its official opening, expanding from an initially largely Hispanic patient pool to

include a greater diversity of ethnic immigrant minorities at present. Dr. Park also reports that the pool of volunteers (professionals and non-professional) has continued to increase as well.

**GCC ReSET (Rehabilitation Support, Education and Training).** The ReSET program is an area of service that GCC launched in the Fall of 2014. It provides transitional and rehabilitative services to educate and train as well as to provide support for local Korean American first generation immigrant women who have experienced major life losses, such as divorce or the death of a spouse. These women have expressed the need for help in rebuilding their lives and rehabilitating their career qualifications as a result of such life events.

Through the individual assessment of aptitudes, qualifications, interests, abilities and job/business opportunities, the ReSET program's goal is to guide, support, and assist service recipients in gaining the relevant education and training necessary to put them on a path to improved financial independence, confidence, and healthy social integration. According to S. Y. Lee, a family law attorney who founded the program, seven to eight participants regularly take part in the program. ReSET also occasionally sponsors special events for members' families such as attending concerts, mentoring programs for individuals who need legal and social services, vocational training programs, and budget management programs that provide hands-on training for participants who desire to open a new business (GCC Working Board Meeting Minutes dated August 1st, 2015).

**GCC Counseling (Washington Christian Counseling Institute).** Since the inception of GCC, the mental health branch, WCCI, has seen the most expansion. The counseling services were born out of necessity in that local Korean American churches needed mental health services consistent with their Christian beliefs in order to refer their congregation members. In addition, due to the limited resources of the small individual churches, the promise of a centralized source



of psychological care was attractive to local church leaders. Here, the “limited resources” include the sufficient professional training, bilingual ability, clinical experience, and spiritual maturity of service providers. A full description of WCCI is provided in the following section. Referring back to the logic model mentioned above, the outcomes (benefits/impact) of the aforementioned services offered by GCC’s three branches are included at the end of this chapter in the discussion of the impact/benefits WCCI and its programs have on people. The outcome of GCC is broader and more inclusive while the outcome of WCCI is more focused on the aspect of mental health, although mental health benefits influence the entire physical, psychological, social, and spiritual health of program recipients.

**Summary of GCC Sub-system.** Table 4.1 provides an overview of each branch of GCC: the GCC Clinic, GCC Counseling/WCCI, and GCC ReSET.

Table 4.1

*Summary of GCC Sub-system*

	<b>Free Medical Clinic (GCC Clinic)</b>	<b>Mental Health (GCC Counseling/WCCI)</b>	<b>Rehabilitative Service (GCC ReSET)</b>
<b>Target Population</b>	Non-insured ethnic immigrants	Korean American individuals and families	Single Korean American women in transition due to major life losses such as divorce or death of spouse
<b>Goals and Objectives</b>	Free medical services	Prevention education, (lay) counselor training and equipping	Empowerment and encouragement by supporting and assisting with relevant education/training for financial independence and social integration
<b>Ongoing Activities</b>	Free weekend clinic	Prevention education seminars/workshops; practicum/internship for counseling students; lay counseling training academy; individual and family counseling services;	Monthly support group meeting; topical seminars/workshops; family social outings; individual mentoring

various activities of three focus groups (Friends of WCCI, WCCI Youth Council, and WCCI Professional Forum)

The remainder of this chapter focuses on WCCI, the mental health branch of GCC. WCCI's organizational structure, its programs, and the people it engages are described. This description is nested within the context of the previously discussed larger GCC system.

### **Description of Washington Christian Counseling Center (WCCI)**

WCCI is the unit of analysis presented in this section to be described using the framework of a logic model. Before going into the details of WCCI, it should be pointed out that the purpose of this case study is to investigate and explain how the services that WCCI offers address the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. It should also be noted that in order to describe the various levels of system and sub-systems, multiple logic models are utilized (Taylor-Powell & Henert, 2008; Yin, 2009); that is, the logic model applied to describe WCCI is nested within the logic model of GCC. In other words, WCCI is one of the outputs of the GCC logic model and thus it is necessary to nest WCCI's subsystem-level logic model within the GCC system-level logic model as illustrated below in Figure 4.9. Thereafter, the sub-system level logic model applied to WCCI is illustrated separately in Figure 4.10.

GCC

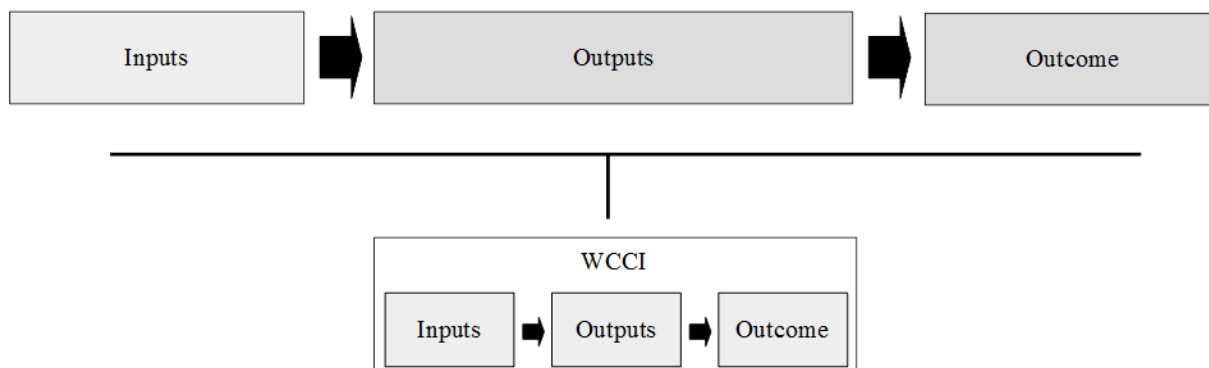


Figure 4.9. WCCI Logic Model Nested within GCC Logic Model

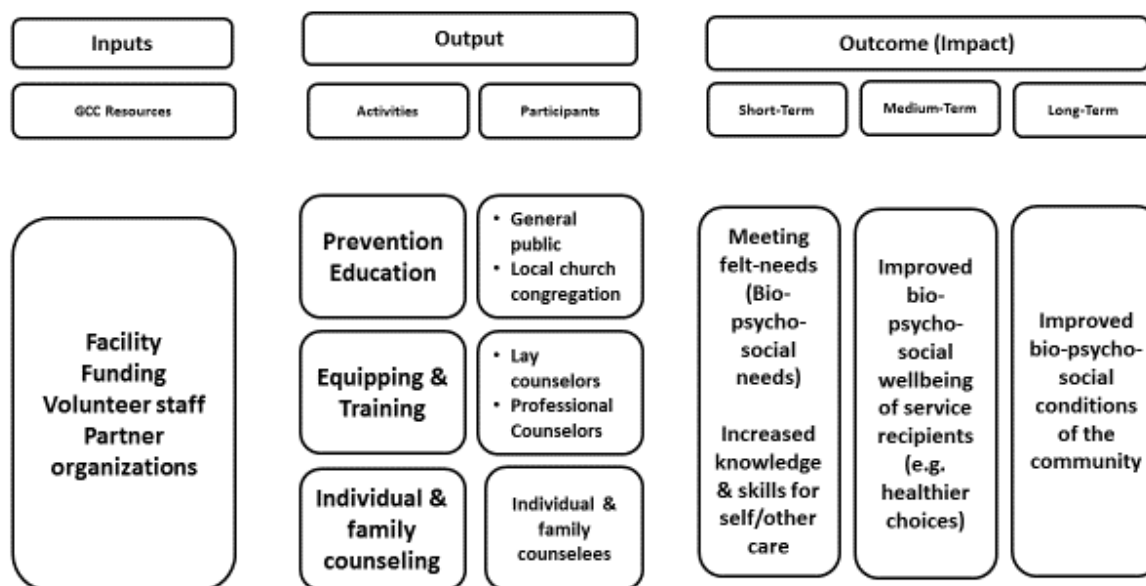


Figure 4.10. Logic Model Applied at the Sub-system Level (WCCI)

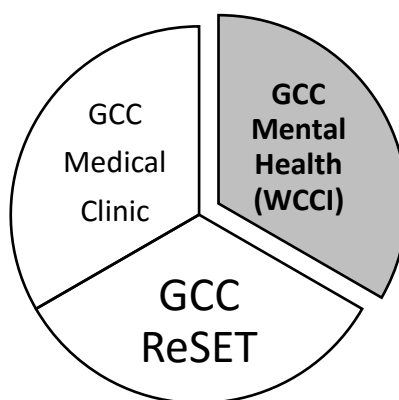
The following are described in detail: the birth of WCCI; its vision and mission; its facilities; its board, staffing and leadership structure; its funding (i.e. financial and other resources); and its partnerships. In addition, the operational strategy (mainly the constructs of

collaboration within and outside of WCCI) is highlighted. An additional description of the operational strategy including integration is provided in the later section that describes WCCI's programs and focus groups.

### **Birth and Evolution of WCCI**

WCCI came into being in 2009, six years after GCC was established. As can be seen in figure 4.11, WCCI is one of three branches of GCC and began as the counseling branch of GCC under the name of Potter's House. Potter's House remained a one-counselor operation for four years until it entered an inactive phase. Following two years of inactivity, a team of five local community leaders and practitioners began meeting to revitalize GCC's mental health-related services. These community members included a family ministry counseling pastor from a large area Korean American church, a women's ministry pastoral staff member from another area congregation, a licensed clinician, an administrator, and GCC's founder Dr. Park.

At that time, the Potter's House was renamed the Washington Christian Counseling Institute and opened its doors once again in early 2009, leading to the first WCCI Counseling Academy for pastoral staff and lay church leaders in local Korean American churches.



*Figure 4.11. GCC and WCCI*

## **Vision and Mission of WCCI**

**Vision.** WCCI is a nonprofit Christian mental health service agency where committed Korean American Christian mental health service providers work collaboratively with service recipients to improve their holistic health in mind, body, and spirit, in order to glorify God. In doing so, not only do they deal with the immediate struggles that program recipients are facing but also work towards the ultimate goal of seeing the image of God restored in the individuals served and their personal growth toward Christ's likeness.

**Mission.** WCCI seeks to serve Korean Americans in the greater Washington D.C. metro area by providing mental health-related services. The scope of services includes, but is not limited to, the area of psychosocial, relational, and spiritual issues. Services provided are founded upon a distinctively Christian worldview and designed to provide professional counseling for individuals and families, training and equipping for present and future leaders, and prevention mental health education to the community at large.

## **Location and Facility**

WCCI is housed within the facility of the umbrella organization GCC. When GCC was first established as a nonprofit entity in 2003, it initially occupied the basement floor of a commercial building in Vienna, Virginia. Strategically situated in a shopping strip adjacent to an apartment complex heavily occupied by recent immigrants and close to the church from which many volunteers could be recruited, the location was chosen in order to maximize the availability of both service recipients and providers. Ten years later in 2013, WCCI moved along with the rest of GCC's programs to its current location in Centreville, Virginia, which is also close to several Korean American churches and near a public housing community with a high underserved population.

## **The Board**

The GCC/WCCI board structure has four committees – clinic, counseling, ReSET, and resources. All board members belong to one of these committees. There are also two different levels of the board – the general board and the working board. The general board mainly secures financial resources and meets once a year while the working board meets more frequently, provides oversight of the organizational operation, and ensures that the organization’s missional goals are being implemented. The working board has typically met bi-monthly in the past but is currently moving toward meeting quarterly instead.

The board members, currently 15 in number, are recruited according to selection criteria that include community serving mindedness, a personal character of “compassion and generosity,” special skills or expertise, personal giving of time and resources, and the recommendation of others. Board members must be voted in unanimously and the length of their term of service is not limited; thus many of the original founding board members are reported to be still active in membership. Some have dropped out since the inception of the organization, partly due to the slow development of the organization over the years. Board chair W. K. Kim stated, “Things were not happening fast enough for some,” as 99% of the organizations are run by volunteers. Mr. Kim also identified Christian faith and the “desire to imitate Christ” as the chief motivation for the board members to begin and remain involved.

## **Staffing and Leadership Structure**

In 2009, five volunteers collaborated in reorganizing GCC’s counseling department Potter’s House as WCCI. Those same volunteers (essentially co-founders) remained as the leadership and principal staff for the next four years, maintaining WCCI’s flat leadership structure and round-table format of decision making. After completing a year-long internship

training at the institute, Dr. J. S. Kim was installed as WCCI's first executive director in 2014. Even with an executive director leading the program, WCCI's leadership structure otherwise remains largely flat, with all decisions still being made in a round-table discussion format and by building consensus. The culture of mutual respect and collaboration among the program's leaders, therefore, remains strong. The operation also became more organized under the new leadership. The appointment of an executive director with the qualifications of being an ordained pastor who is also a trained professional counselor seemed to agree well with the norms of Korean American culture and the faith-based nature of the organization.

### **Funding, Financial and Other Resources**

Framing WCCI's finances within the context of GCC, an innovative approach to resolving resource constraints across the organization lies in GCC's fundraising strategy. The GCC board allows and encourages separate fundraising by the three major branches of the organization – the medical clinic, WCCI, and ReSET. Each department is allowed to plan and carry out their own fundraising events targeting donors related to the specific services offered by their department. In this way, each fundraising campaign scheme can be tailored to the needs of the particular department raising funds. In addition, it was hoped that this method of raising funds would be relatively easier than conducting an organization-wide campaign, and that it would lead to the employment of a wide variety of fundraising efforts.

At the time of GCC's birth, no formal funding sources were in place; initial funding for the organization consisted solely of individual donations from the GCC leadership and in-kind donations from various local church congregations. One congregation (Korean Central Presbyterian Church), for example, covered the cost of renting the organization's first headquarters in Vienna, Virginia. In addition, WCCI did not initially seek governmental grants

and supports as other nonprofit ethnic organizations had, mainly because of the perception that faith-based community organizations may become secularized in the process of incorporating public/governmental support into their financial support structure, and thus see their original intent for spiritual emphasis diluted.

In recent years, though, WCCI has begun seeking increased collaboration with the local Fairfax County government, initially with a proposal submission to the Partners In Prevention Fund (PIPF) through the Fairfax County Department of Neighborhood and Community Services in 2011. This increased collaboration with the local government without compromising the spiritual integrity of the organization has opened up new possibilities for funding streams. However, the annual fundraising event (in addition to private contributions) remains as the main source of funding. In previous years, Friends of WCCI has hosted annual fundraising dinner events with the assistance of various local Korean American churches in providing facilities. Community leaders are invited and their support is solicited through a program including an organizational presentation, entertainment, and fellowship. This aspect of WCCI is discussed in more detail in the section on Friends of WCCI.

### **Partnerships**

WCCI's system of partnerships is twofold. Partnerships can be observed intra-systemically within WCCI itself as well as inter-systemically with other organizations in the community. With regard to inter-systematic partnerships, WCCI seeks to provide a stable, ongoing professional center to meet the mental health needs of the members of various local churches within the Korean American immigrant community. A network of local Korean American immigrant churches support GCC/WCCI and its programming through financial contributions and through referrals and recommendations. There is an inherent trust among the



churches to release their members to WCCI because of its faith-based service reputation. As indicated in the literature review in Chapter Two, many Korean Americans respond to their mental health needs by seeking informal channels of support such as pastors and other religious leaders. Therefore, the linkage between WCCI and local churches is vital to WCCI's partnership with those outside the organization.

The significant value of WCCI to local churches can be seen not only in their affirmation of and referrals to WCCI for services, but also in the way of financial support such as monthly contributions. Several area Korean American churches have made an ongoing commitment to provide monthly financial support and have budgeted the amount as a part of their regular expenditures. It is important to note that much of the establishment of these contributions has been facilitated by individual church leaders who have benefited from WCCI's education and training initiatives.

In addition to relationships with local Korean American churches, partnerships exist between WCCI and organizations in a wider social context beyond the circle of the Korean American community. WCCI's partnership with the Fairfax County Department of Health and Department of Human Services, for example, allows WCCI (and GCC as a whole) access to various government resources. In addition, the county health department and private sector organizations such as the INOVA Health System and its associated clinicians (doctors, nurses, pharmacists, and labs) are engaged with GCC in collaborating to meet the needs of otherwise underserved populations.

Intra-systemic partnerships are also evident at every level of WCCI's departments, programming, focus groups, and participants. For example, the WCCI Youth Council (a group of high school students being equipped with mental health education to make an impact among

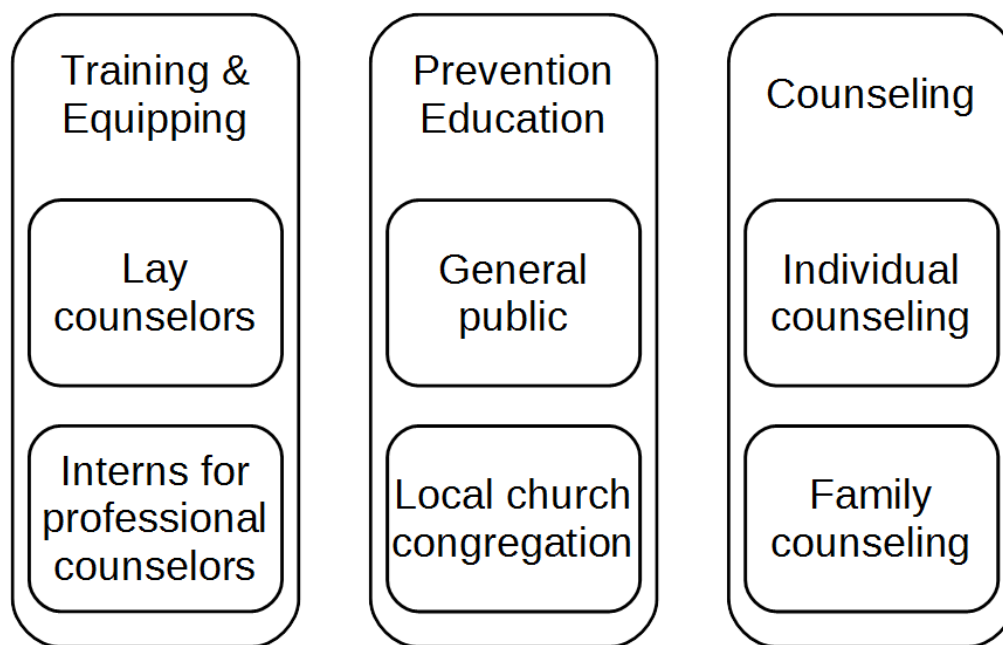
their peers) benefits from services provided by volunteer staff who are also WCCI Professional Forum members. The volunteer staff in turn are beneficiaries of services offered by the WCCI Professional Forum such as professional development and networking opportunities. The common goal of these partners is to raise mental health awareness and increase mental health literacy in the Korean American community as a whole as they simultaneously provide and receive benefits in their participation with WCCI. More detailed descriptions of collaboration are discussed in the WCCI program section.

### **WCCI Programs**

In the foregoing, WCCI's three program areas and three different focus groups of participants are described. Applying the logic model on this level, these can be identified as the outputs of WCCI. Outputs explain what is being done for whom with the inputs (i.e. the resources of WCCI). The constructs described here are the programs and their goals and objectives. Following the description of the three program areas and the special focus groups, the constructs are discussed as collaborations existing between programs and people. The integration of different elements including spiritual, sociocultural, and language adaptation and community stakeholder engagement are also discussed.

### **Evolution of the Programs**

WCCI's programs have evolved into what are currently three distinctive categories of programs. The categories include training and equipping, prevention education, and counseling. WCCI's program categories are further illustrated below in Figure 4.12.



*Figure 4.12. WCCI Programs*

### **Equipping and Training Programs**

In June of 2009, the first Counseling Academy was held to educate local church leaders in the Korean American community about mental health issues. A total of 38 attendees including pastors and their wives, missionaries, and lay leaders participated in the weekly training over a three-week period. As is the case with regard to GCC as a whole, most of WCCI's programs have been born out of needs identified in the community, and the Counseling Academy is no exception. The following staff email provides a window into the nature of and process by which the training came to be:

In WCCI's effort to be sensitive to the particular needs of the attendees, we've been keeping our eyes and ears open to listening to what might be most practical and helpful. To that end, I need to inform you that there have been requests to teach "therapeutic processes" for your Counseling Skills seminar. The questions include:

- What takes place during the first counseling session?
- What is the order of business during an hour of counseling?
- Should there be a structure and, if yes, what kind of structure?
- How to do time management during a counseling session
- How to sift through or sort out what is pertinent information and what is not
- How best to guide counselees with relevant questions and in time efficient way
- Use of (when and how) Scripture and prayer

In short, it would be greatly appreciated if you could address the above questions (and/or more) in regard to a typical counseling process in addition to your intended discussion.

Thank you very much. I am looking forward to the first day. (Email correspondence, May 2009)

The first public announcement of the academy took place in an article and an advertisement about WCCI in the Christian Power on May 29, 2009, announcing the Counseling Academy for Servant Leaders of area Korean American churches that was to begin on June 8, 2009 for three weeks at GCC. Interest in the training was greater than expected, and thus the academy had to relocate to a larger space to accommodate the high number of attendees. In addition, the organization's first website was up and running as of June 22, 2009.

Since its inception, WCCI continued to offer the Counseling Academy every spring and Fall (and in some years in the summer as well) for three to four hours per week for a duration of five to six weeks. The program was also expanded to include levels I, II, and III as many of the attendees desired to continue on with the education. The Counseling Academies were so well received that some of the participants formed a group of their own initiation to receive continuing education in the area of counseling and mental health issues and named themselves

“Friends of WCCI.” This was the origin of the first of the three focus groups that currently exist and which is described in further detail.

The target population for the Counseling Academy educational series were ministers and lay leaders in local Korean American churches. The academy seeks to provide distinctively Christian counseling principles and their application in ministry in order to augment the knowledge and skills of those who are already serving people in their respective ministries.

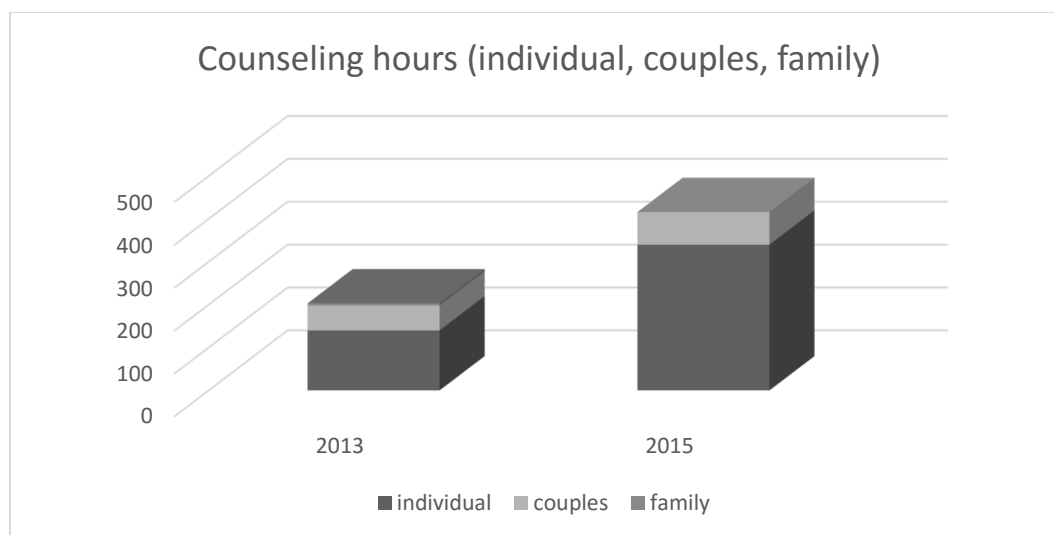
Naturally, the training and equipping of lay leaders expanded to training those who desired to enter into a professional career in the counseling field. In collaboration with existing educational institutions such as colleges and universities, WCCI training and equipping programs offer a platform for internship for those who are already in a professional counseling degree program at an accredited institution. It seeks to provide the clinical experience of working specifically with ethnic minority clients, largely Korean Americans. The current executive director was the first intern admitted to this program in 2012 and at present time, there is a master’s level student completing her internship for Liberty University. Continuing education is provided through WCCI Professional Forum.

### **Counseling Services**

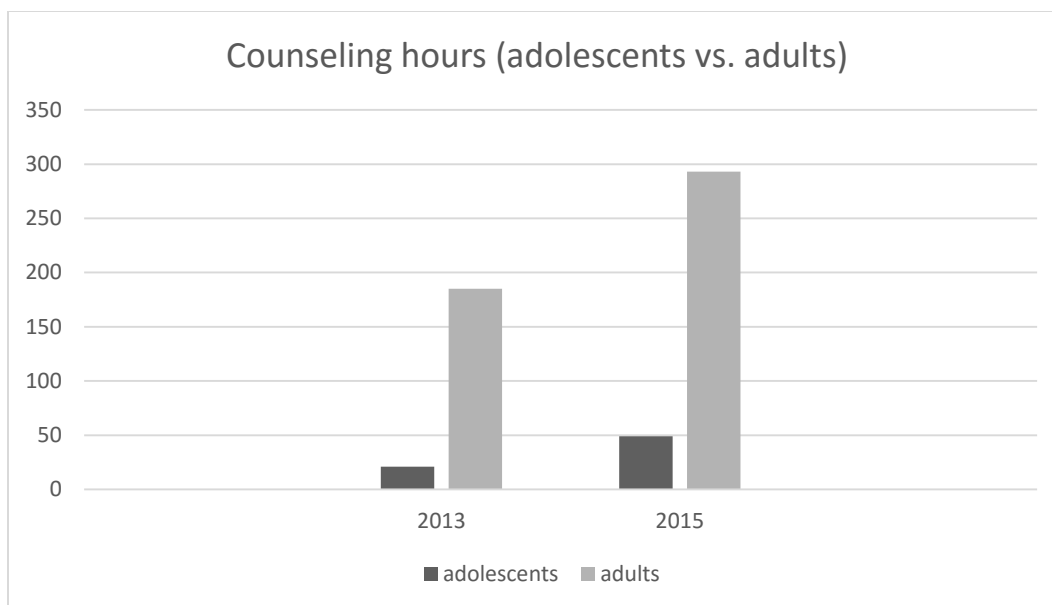
Through these Counseling Academy attendees, referrals for counseling services at the institute began and the demand for services has continued to expand ever since. The counseling services (individual and family counseling) are open to all who are in need but are not able to access mainstream clinical services due to language barriers, or those who prefer culturally informed counseling. According to a presentation dated April 2013, a total of 213 individual or family face-to-face clinical counseling sessions were provided by primary counselors. Of those hours, approximately 70% were individual sessions, 28% were couple sessions and 2% were

family sessions. Adults comprised 90% of the service recipients and adolescents 10%. A new website ([www.wccigcc.org](http://www.wccigcc.org)) was established in 2014 where prospective counselees can directly schedule counseling appointments and obtain information about upcoming trainings or other educational opportunities. The 2015 annual face-to-face counseling report recorded a total of 416 hours of counseling provided, with 82% being individual sessions and 18% being couple sessions and 86% of the counselees being adults and 14% being adolescents.

A breakdown of the face-to-face counseling sessions are presented in Figures 4.13 and 4.14. In Figure 4.13, the breakdown in hours is shown according to type of counseling provided, whereas in Figure 4.14, the breakdown is according to types of counseling recipient.



*Figure 4.13. Face-to-Face Counseling Hours by Type of Therapies Provided*



*Figure 4.14. Face-to-Face Counseling Hours by Recipient Categories*

As illustrated above in Figures 4.13 and 4.14, the counseling hours provided grew 100% from 213 to 416 hours in less than two years. The number of hours grew in each of the categories of services provided (individual, couples, family) as well as the categories of service recipients (adults, adolescents). It is noteworthy that the counseling staff number did not increase during this time, thus greatly increasing the demands upon the organization's counseling staff.

### **Prevention Education Programs**

Prevention education efforts are twofold in focus in that prevention seminars and workshops target local church congregations as well as the general public. Both are offered in Korean to audiences who mostly identify themselves as first-generation immigrants who benefit from learning in Korean. Following the first year of Counseling Academy training for local church leaders, WCCI held its first prevention program aimed at educating the general public in the Korean American immigrant community through a one-day parenting seminar on March 20,

2010. The event, which was attended by 68 Korean American parents of teens, was hosted by Light Global Missions Church, a local Korean American church, and sponsored by Friends of WCCI, who provided services and met various attendee needs.

A few months later, on July 31, 2010, another parenting seminar that focused on parenting issues faced by parents of younger school-aged children was hosted by a different Korean American church, the Korean Central Presbyterian Church. This seminar was not intended for the general public but was designed for specific church congregation members. Over 35 parents attended the seminar and expressed continuing interest for further education on similar topics. As such, WCCI continued to provide prevention education seminars tailored to either the general public with community-wide promotion or for specific church congregation needs and/or requests.

In general, WCCI's prevention education target population is community residents, mainly Korean-speaking first-generation immigrants and their families who likely lack access to mainstream resources. Such efforts seek to empower individuals through mental health awareness education in order to prevent or minimize possible problems within families and the community. Prevention education includes parenting education, couples workshops, and topical trainings. Table 4.2 summarizes the target population, goals and objectives, and ongoing activities for each of WCCI's program categories.

### **Summary of Programs (Services)**



Table 4.2

*Summary of WCCI Programs (services)*

	<b>Community Education (Prevention Education)</b>	<b>Counselor Education</b>	<b>Counseling Services</b>
<b>Target Population</b>	Local church congregations; Neighborhood community outreach	Graduate and post- graduate students; local church lay leaders	Individuals, couples, and families
<b>Goals and Objectives</b>	Raising mental health awareness	Training and equipping	Healing and restoring
<b>Ongoing Activities</b>	Topical seminars and workshops	Counseling Academy I, II, and III	Counseling services by appointment

WCCI programs at GCC makes it possible for local Korean American immigrants to access mental health-related services and play a meaningful role in the health of the community. WCCI has historical, cultural, social, spiritual, and moral significance to those whose primary language and culture exclude them from being mainstream service recipients.

### **WCCI Focus Groups**

In order to better serve members of the Korean American immigrant community, WCCI programs have adapted to the Korean cultural norm of emphasis on education. In addition to utilizing the educational format of prevention education, training lay counseling leaders, and offering internships, there are three special focus groups within WCCI that also operate with an educational emphasis for receiving psychoeducational services. These are the Counseling Academy for the lay counselors that make up Friends of WCCI, educational seminars for WCCI Professional Forum members, and early mental health education for the WCCI Youth Council (Figure 4.15).

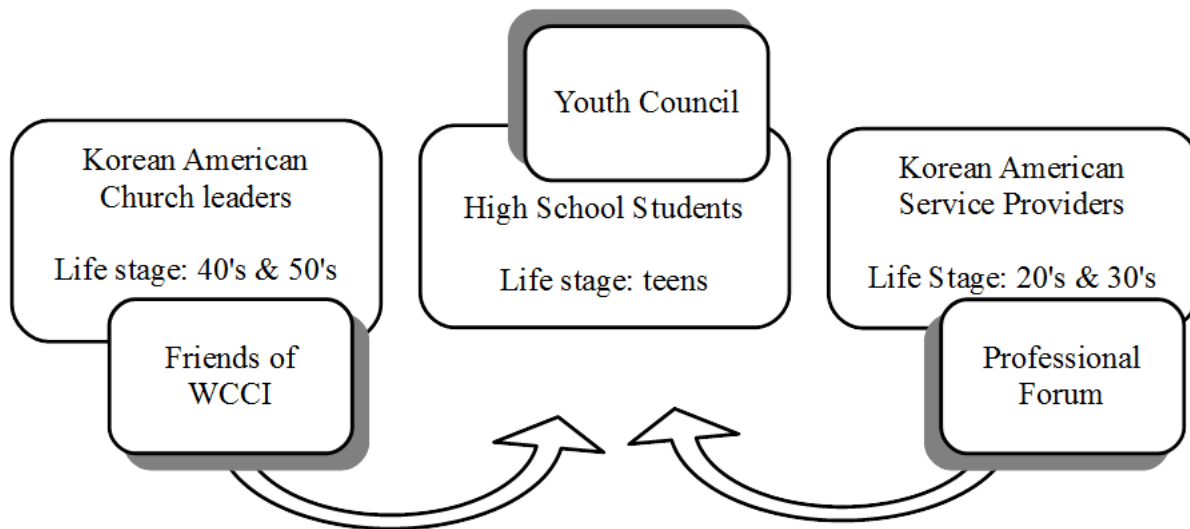


Figure 4.15. WCCI Special Focus Groups

### Friends of WCCI

The Friends of WCCI (also referred to as the “*Friends*”) is a community of WCCI Counseling Academy graduates who are also local church leaders. The Friends came into being following the first Counseling Academies I and II. Initially, they met amongst themselves to continue sharing in the context of a small, intimate therapeutic community of approximately a dozen members. With the realization of their need for support in order to continue to grow in their counseling skills and knowledge, the group reached out to WCCI volunteer clinicians for continuing education, leading to the commencement of monthly and periodic topical training seminars. The first group of Friends was formed in 2010 and a second group of Friends was formed at the end of 2014 through the process of taking part in Counseling Academies followed by a shared desire for continuing education, deeper fellowship, and ongoing supervision amongst the cohort members.

The Friends meet bi-weekly, once on their own and then once with WCCI supervising staff to receive continuing education and/or consultation. While they continue to strengthen their competencies, they also sponsor activities of their own accord including fundraising for WCCI.

In November 2015, for example, the Friends held a One-day Tea House Fundraising event at a teahouse (Soricha Tea and Theater) in Annandale, Virginia in an area with a high concentration of Korean American immigrants. The Friends pre-sold tickets for the event and prepared an assortment of traditional Korean teas and refreshments along with a performance of traditional Korean music. During the event, a silent auction was also held with attendees bidding on various items donated by supporters including handicrafts made by the Friends. Yearly fundraising efforts like these serve to meet not only the financial needs of WCCI but also to increase the spirit of volunteerism and collaboration within and outside of the organization.

The Friends of WCCI is an exemplary group and holds a critical importance for WCCI. Their active participation in and support of a variety of WCCI events speak of their level of commitment and dedication. In reflecting on her experience as a member of the Friends, Y. M. Kim said, “We very openly share our struggles in this group and the positive impact of my fellow Friends has been invaluable over the past several years of my life.” Several members also stated that the group provides a safe place to talk about things that they cannot otherwise discuss due to the leadership positions they hold in their respective churches. Such reflections are corroborated by executive director Dr. J. S. Kim who has been providing the second group of Friends with continuing education. He reported that the Friends seem to freely share about their personal struggles in the group and receive feedback offered in the context of group cohesiveness and the therapeutic small group culture.

The Friends of WCCI meetings were observed on two different occasions. The first observation was performed in September of 2015 when both groups of Friends convened together for the purpose of fellowship and planning. The gathering was held in the home of S. Park, a volunteer clinician that provides continuing education/consultation for the first group of

Friends. Present were three volunteer staff members and 14 Friends. Each member brought a dish to share, so the table was full of food and there was a lot of chatter and laughter around the table. The first half an hour of food and fellowship was followed by an informal meeting time of 90 minutes led by the executive director. Four discussion items were presented including the upcoming Counseling Academy, the annual fundraising event, and new ministry ideas such as special seminar for men only and a Counseling Academy for couples. Everyone present participated in the brainstorming and decision making. A high level of enthusiasm and collaboration was observed. Many suggestions were made regarding how to improve future Counseling Academies, seminars, and workshops, with regard to both content and logistics. Almost all the Friends who were there volunteered to perform specific tasks related to the execution of the upcoming educational and fundraising events, demonstrating how the organizational events and programming are driven by grassroots volunteers and service recipients.

The second observation took place in a WCCI conference room when the second group of Friends met for a continuing education session. Present were five Friends and the executive director who led them in a discussion of a book on boundaries that they had been reading as a group. The Friends processed the concept of boundaries proposed in the book through group discussion where the individuals present utilized examples from their own personal situations. There was much mutual education as the participants shared their experiences and reflected on them together. All of the participants present were very open and highly expressive in sharing their personal experiences. Acceptance and positive regard for one another were visible. Particularly noteworthy was discussion of how to adapt the concept of boundaries to Korean cultural norms. As the participants discussed certain scenarios that were used as illustrations in

the book, they noted how such incidents might be handled differently in the context of the Korean American family system. Such instances of the tailoring of material to be culturally appropriate were evident across the various programs and corroborated by interviews, observations, and document reviews.

### **WCCI Youth Council**

The WCCI Youth Council was formed to promote mental health literacy among area Korean American youths through education, conferences, and Christian fellowship. The birth of the WCCI Youth Council took place in 2012 following WCCI's first Youth and Family Mental Health Conference in order to continue to raise awareness of mental health needs among Korean American youths and their families.

WCCI Youth Council members and its staff meet regularly to fellowship and to discuss various mental health issues relevant to teen life. A range of topics are covered including the area's culturally diverse school environment, biases and stereotypes, and bullying as well as common mental health issues such as depression, anxiety, and addiction. The WCCI Youth Council provides an opportunity for teens to talk about these topics, some of which are difficult to discuss, in a safe, small group setting where confidentiality is ensured. In turn, WCCI Youth Council members plan and host annual mental health projects such as a youth conference to educate local teens and families.

WCCI Youth Council members include local Korean American Christian students that attend public or private high schools in the Washington, D.C. metro area. Information about WCCI Youth Council membership is shared primarily by word of mouth among the students and their parents, with each member being selected through an initial written inquiry followed up by

an examination of the student's motivation and qualifications. One WCCI Youth Council inquiry was recorded as follows:

I am a sophomore... my church youth group was recently visited by the WCCI Youth Council and I became very interested in becoming a member. I have had a family member struggle with a mental disorder, and watching them go through it was very difficult for me. I still have trouble with communicating to people in our community about it, and I think a group like the WCCI Youth Council would make a very large impact on the way our community views mental illness. I've recently been baptized, and going on that journey also has motivated me to do something to make my relationship with God more evident and stronger. I want to become a part of something that will take measures to promote God's word while bettering our world, and I think that this is the perfect opportunity. I would put in all my effort towards this, as it is a very important and relevant topic that I care about tremendously.

As illustrated in this inquiry, the conflicts expressed point to the need for culture-specific, faith-informed mental health education and WCCI Youth Council seeks to serve such needs.

The goals and objectives of the WCCI Youth Council are as follows. The short-term goals for the group are mental health education, fellowship, and professional staff support and mentoring. The long-term goals and objectives are to help individuals become servant leaders who can reach out to peers in need, and to foster a collective advisory think-tank for WCCI's future outreach efforts, focusing on the needs of area youth, both Korean American and beyond.

The following is an account of a typical WCCI Youth Council meeting that was observed. A few minutes before the meeting was to begin at seven o'clock on a Thursday evening, the students began to congregate in a conference room at the GCC/WCCI office. By

the time the meeting started, there were seven high school students and two volunteer staff present. One parent had prepared sandwiches for dinner for the meeting, so the first half an hour was spent with students and staff casually eating and talking as they caught up with each other. For the next 45 minutes, the staff introduced the students to an interactive online training program called Friend2Friend which trains youth to “recognize and help when your friend is struggling with mental health” (<http://kognitocampus.com/peer>). It was observed that the students made frequent cultural references and comparisons as to how the examples used in the program might need to be handled differently in a Korean family context, with staff responding to as well as eliciting comments from other students.

### **WCCI Professional Forum**

The WCCI Professional Forum consists of a group of Korean American service providers in mental health and human services professions, including psychologists, psychiatrists, social workers, school counselors, health specialists, and family ministers from local Korean American churches. The members meet regularly to network, fellowship, and discuss issues of interest for professional development.

In regard to their professional development, the Forum seeks to establish ongoing dialog amongst Forum members relating to important subjects such as the integration of spirituality and psychology as well as other challenging issues in counseling including gender, marriage, sexuality, and relationships. Forum members share a common understanding of and desire to serve the Korean American community even though most of them work in the mainstream public/private sector.

Unlike the WCCI Youth Council, there is no official membership in the WCCI Professional Forum and “members” do not need to meet any requirements or make any

commitment in order to take part in the Forum's activities. All are welcome at occasional Forum-hosted events geared towards promoting individual professional development and/or collective efforts to contribute to community development. For example, at one such event the Forum hosted a guest speaker, a Korean American pastor who is also a psychiatrist of thirty some years, in order to learn more about a biblical perspective on psychiatric disorders. It should be noted that although Forum members generally adhere to the Christian faith, very few were educated in Christian institutions or programs, and thus welcome the opportunity to learn and freely discuss integration issues in their work. Figure 4.16 presents an illustration of how the Forum can impact service providers by offering the aforementioned opportunities.

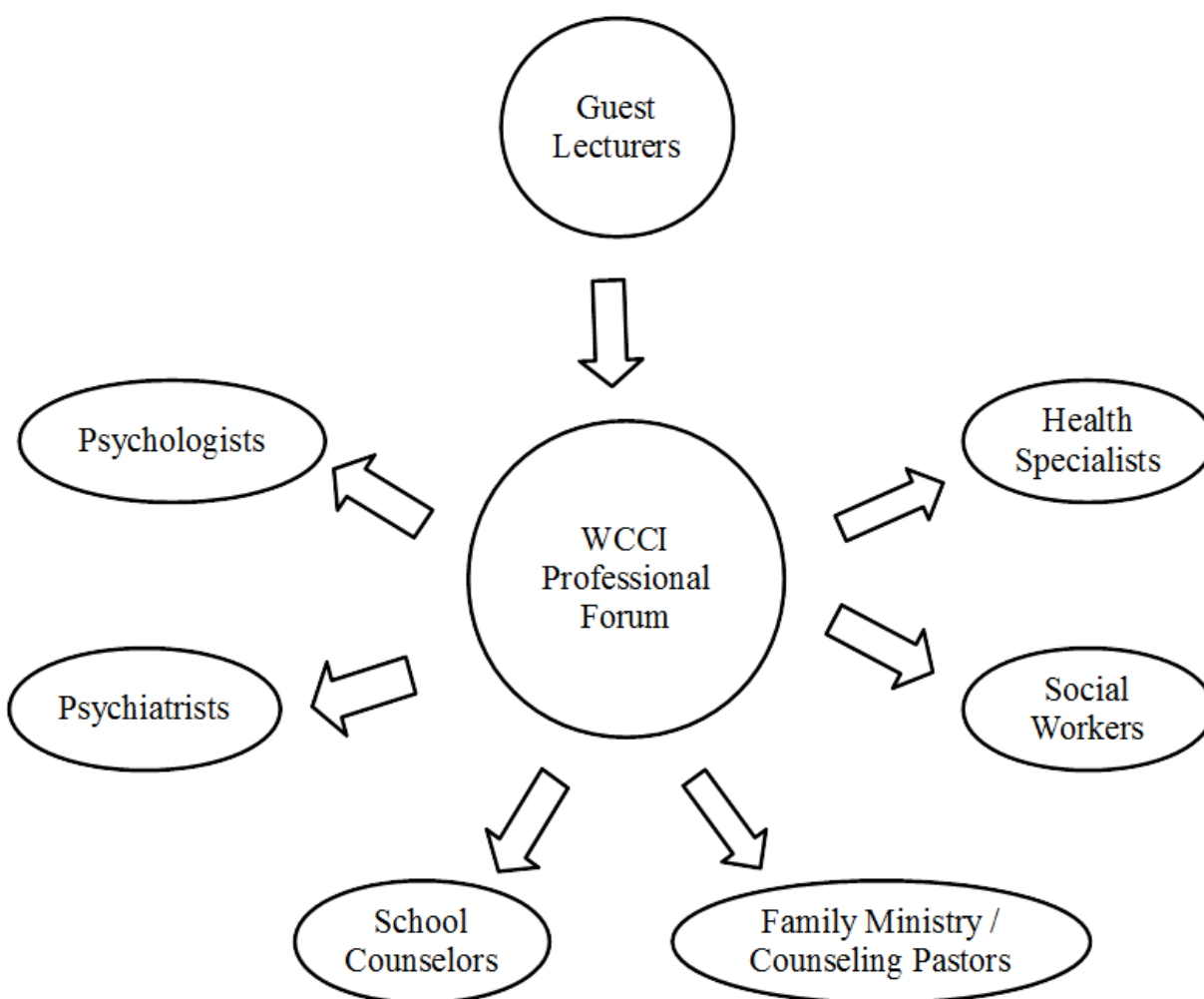
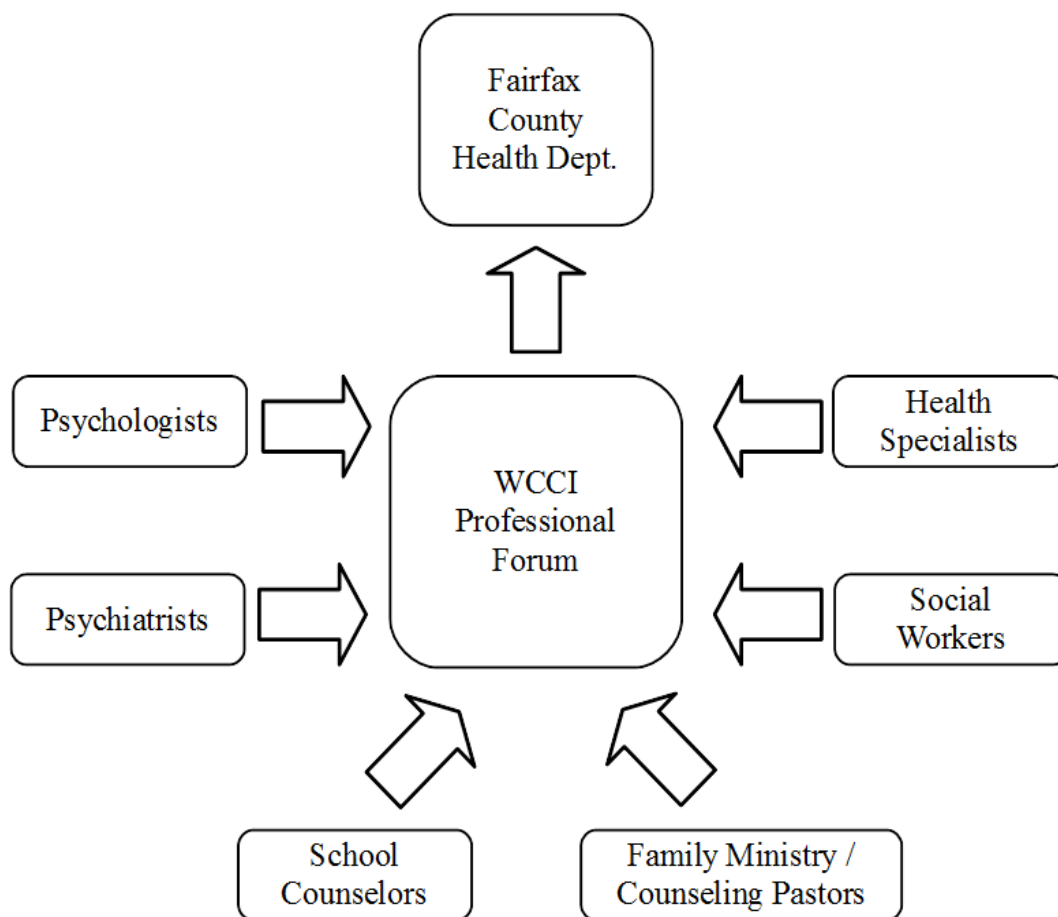


Figure 4.16. WCCI Professional Forum: Pathways of Impact



The Forum can also serve as a platform by which other service providers who are less accustomed to the Korean cultural norms may receive information. In this way, the Forum can provide pathways for members to make contributions as illustrated in Figure 4.17 below. For example, the Forum also hosted an event on February 7, 2016 where a community health specialist from the local county was invited to hear the perspective of Forum members on the cultural aspect of Korean American's dealings with mental health issues. The following is an excerpt from an email calling for a gathering of the WCCI Professional Forum:

One of our new members to the WCCI Professional Forum is P. K. who is now working for the Fairfax County Health Department and is assisting the county's effort to reach out to ethnic minority communities. The county is very much interested in promoting mental health and is especially interested in getting our insight on spiritual/cultural aspect in mental health as it pertains to our Korean American community. As a Korean American mental health practitioner, we have a social responsibility to contribute to such efforts. We would like to hold a Professional Forum to address the questions the county Multicultural Advisory Team has posed to us. Would you be available on... for this purpose?



*Figure 4.17. WCCI Professional Forum: Pathways of Contribution*

Table 4.3 summarizes the target population, goals, objectives, and ongoing activities of the WCCI focus groups, (Friends of WCCI, WCCI Youth Council, and WCCI Professional Forum).

### Summary of Programs (Focus Groups)

Table 4.3

#### *Summary of WCCI Programs (Focus Groups)*

	<b>Friends of WCCI</b>	<b>WCCI Youth Council</b>	<b>WCCI Professional Forum</b>
<b>Target Population</b>	Local Korean American church leaders (i.e. small group leaders)	Local Korean American high school students	Korean American counseling professionals (i.e. school counselors, social workers, psychologist and psychiatrist)
<b>Goals and Objectives</b>	Equip and train local church leaders to better serve their congregation	Raise mental health awareness among young people	Facilitate networking among Korean American counseling professionals
<b>Ongoing Activities</b>	Bi-weekly consultation/supervision meetings; continuing education workshops	Bi-weekly group meeting (mental health prevention education and fellowship)	Quarterly professional enrichment training and fellowship

### **Operational Strategy: Collaboration and Integration**

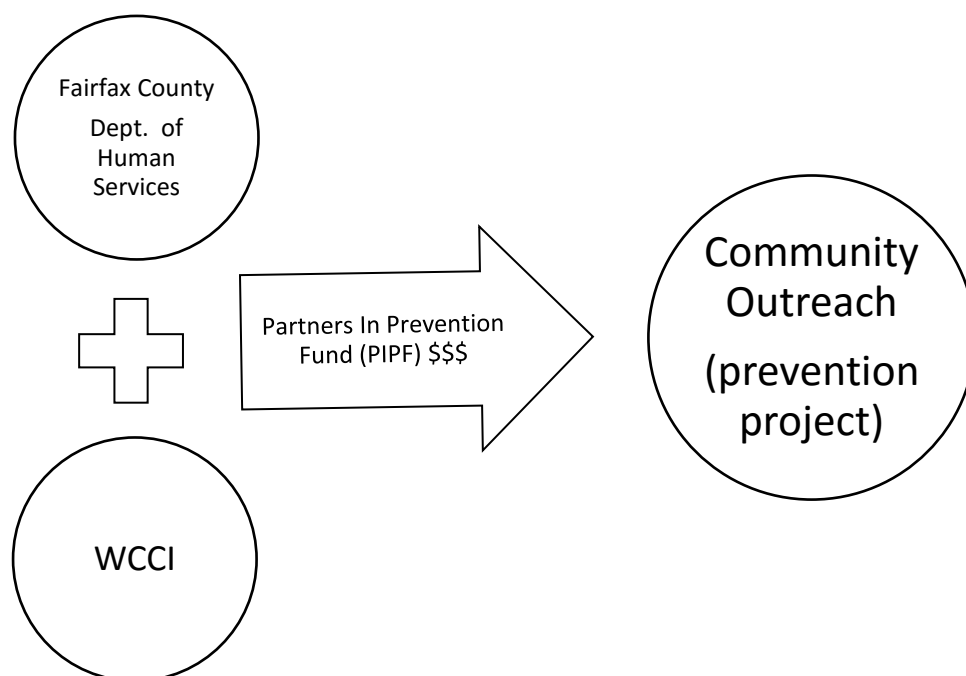
The workings of partnerships are illustrated in WCCI's operational strategy. As mentioned briefly during the discussion of partnerships, WCCI's operational strategy was not planned out from the beginning but rather has naturally evolved from gaining awareness of needs within the community over the course of carrying out the organizational mission. Collaboration and integration are the two most evident constructs in WCCI's operation, bi-directionally with other organizations as well as with the parent organization. Collaboration is also evident in all levels of the programs and people involved in those programs. Forgoing is the more detailed

description and illustration of such. At the end of the section, a comprehensive overview is illustrated in Figure 4.20.

### **Collaboration**

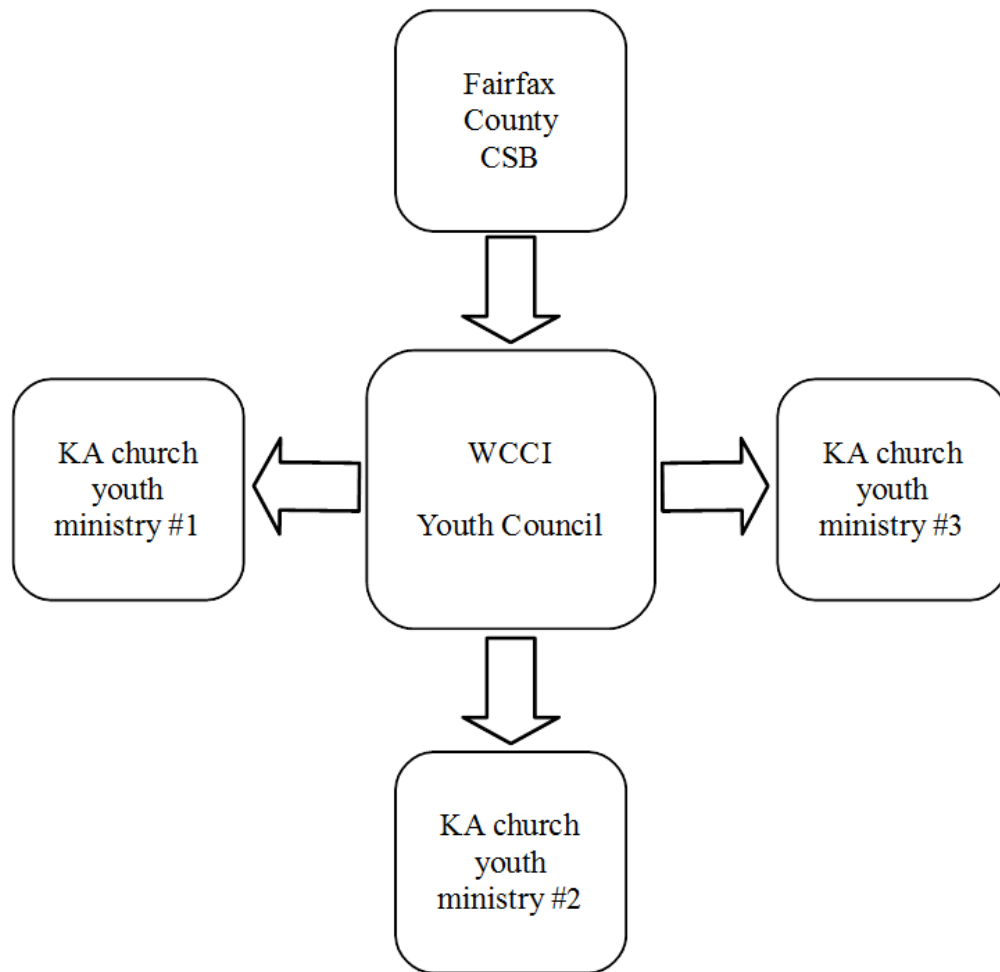
Collaboration has been an effective partnership strategy both within GCC and with outside organizations. Collaboration takes two forms. First is the inter-organizational collaboration where collaborative efforts are made that involve organizations external to WCCI or its programs. A network of local Korean American immigrant churches supporting WCCI is an example. Another example can be seen in WCCI's collaboration with the local county government, more specifically the Fairfax County Department of Human Services. Second, intra-organizational collaboration can be observed at every level of WCCI's various departments, programming, and focus groups.

Regarding inter-organizational collaboration, in 2011, the Fairfax County Department of Human Services issued a request for proposals to solicit evidence-based prevention programs for county residents, primarily for children, youth, and families (Retrieved from <http://www.fairfaxcounty.gov/ncs/prevention/pipf.htm>). The diagram in Figure 4.18 illustrates the mutual engagement by WCCI and Fairfax County for the betterment of ethnic immigrant communities such as the Korean American community.



*Figure 4.18. Inter-organizational Collaboration (WCCI Professional Forum)*

Another example of collaboration is WCCI's yearly Youth Council project. For their yearly mental health project during the 2014-2015 school year, the WCCI Youth Council applied for a Fairfax County mini-grant as part of the Youth-Led Mental Health Stigma Reduction Project. With the help of WCCI Youth Council staff volunteers, the WCCI Youth Council members wrote a proposal to reach out to Korean American youths in the area through local Korean American church youth groups. The WCCI Youth Council was among six local youth organizations that were awarded grants (<http://www.fairfaxcounty.gov/csb/news/2015/fighting-stigma.htm>). Figure 4.19 presents how the WCCI Youth Council facilitates collaboration across multiple organizations.



*Figure 4.19. Inter-organizational Collaboration (WCCI Youth Council)*

In the proposal submitted to the county, the WCCI Youth Council expressed its intentions as follows: “The purpose of our project ‘Educate to Empower’ was to educate our fellow Korean American peers about the stigma associated with different mental health issues. What we wanted to do was to empower them to help their classmates and also to enable them to go out into their own communities and spread awareness about mental health.” (GCC, 2015). The WCCI Youth Council members planned and implemented the project by creating a presentation, designing T-shirts, and making a music video clip on mental health; they also visited local Korean American church youth groups in order to engage a larger circle of Korean American

youth. The WCCI Youth Council's final report indicated that they successfully completed a peer-to-peer mental health educational campaign reaching approximately 200 youth representing more than 10 area high schools through three different local Korean American church youth groups (Youth Council, 2015). Through such collaboration, a mutual goal of outreach to the community is served.

### **Integration**

Integration is a key component of WCCI's operational strategy. Integration in this context refers to intersecting combinations of community-centeredness, underlying Christian faith and cultural relevance, culminating in the effectiveness of WCCI and its programs. For example, the collective efforts of WCCI Professional Forum members to integrate faith and cultural relevance into their work is evident in their goals for a recent meeting held on February 7, 2016: "Not only faith integration, but also the effort to make impact in integration of cultural relevance into the services made available by the public agency such as local government is worthwhile effort." Another good example is the Fairfax County grant programming illustrated in Figure 4.18, which allows a fair amount of faith integration and cultural adaptation, provided that the fidelity of the awarded grant goals and objectives are preserved.

Also integrated into WCCI's work is a cultural understanding that results in certain adaptations. A good illustration can be seen in the work of WCCI Youth Council members on the "Educate to Empower" project in 2015 (Figure 4.17). Their presentation included a section titled "Saving Face" which sought to challenge the shame-based culture of the Korean American community. Similar adaptations are made in the content of the Counseling Academy programs for local leaders, prevention education seminars for the general public, and for individual or family counseling when permitted by clients.

In addition, WCCI seeks to integrate the spirituality of the Christian faith internally at every level of the organization and its programming (i.e. content). One WCCI Youth Council member offers the following thought which shows consistency with the program goals and objectives while also aligning with the mission and goal of the organization:

I used to think, ‘I am feeling anxious or people feel depressed because they weren’t praying hard enough or go to church every week...’ [but] being in youth council and us discussing those issues... now I know it’s a myth and knowing that is comforting... it’s been helpful to be a part of the WCCI Youth Council.

Therefore, the unified effort to integrate faith, culture, and a sense of cohesive community can be seen consistently across the organization.

### **Special Programs and Projects (Grants)**

As illustrated in Figure 4.18 above, WCCI engages at a larger community level by applying for local government grants including a PIPF grant through the Fairfax County Department of Human Services. As a result, WCCI was selected along with seven other different local nonprofit community agencies to run several of the eleven evidence-based programs that support area at-risk children and families (Fairfax County of Virginia, 2015). Most recently, WCCI conducted a PIPF-supported program called Lifelines that supports key prevention system goals for youth and family mental health. WCCI provided the program for the WCCI Youth Council members and their guests as well as for a local Korean American church youth group. The program was adapted to include cultural issues and scriptural references. Such adaptation in special programs and projects illustrate the aforementioned integration and collaboration. Figure 4.20 below presents a comprehensive overview of collaboration occurring within and outside of WCCI.



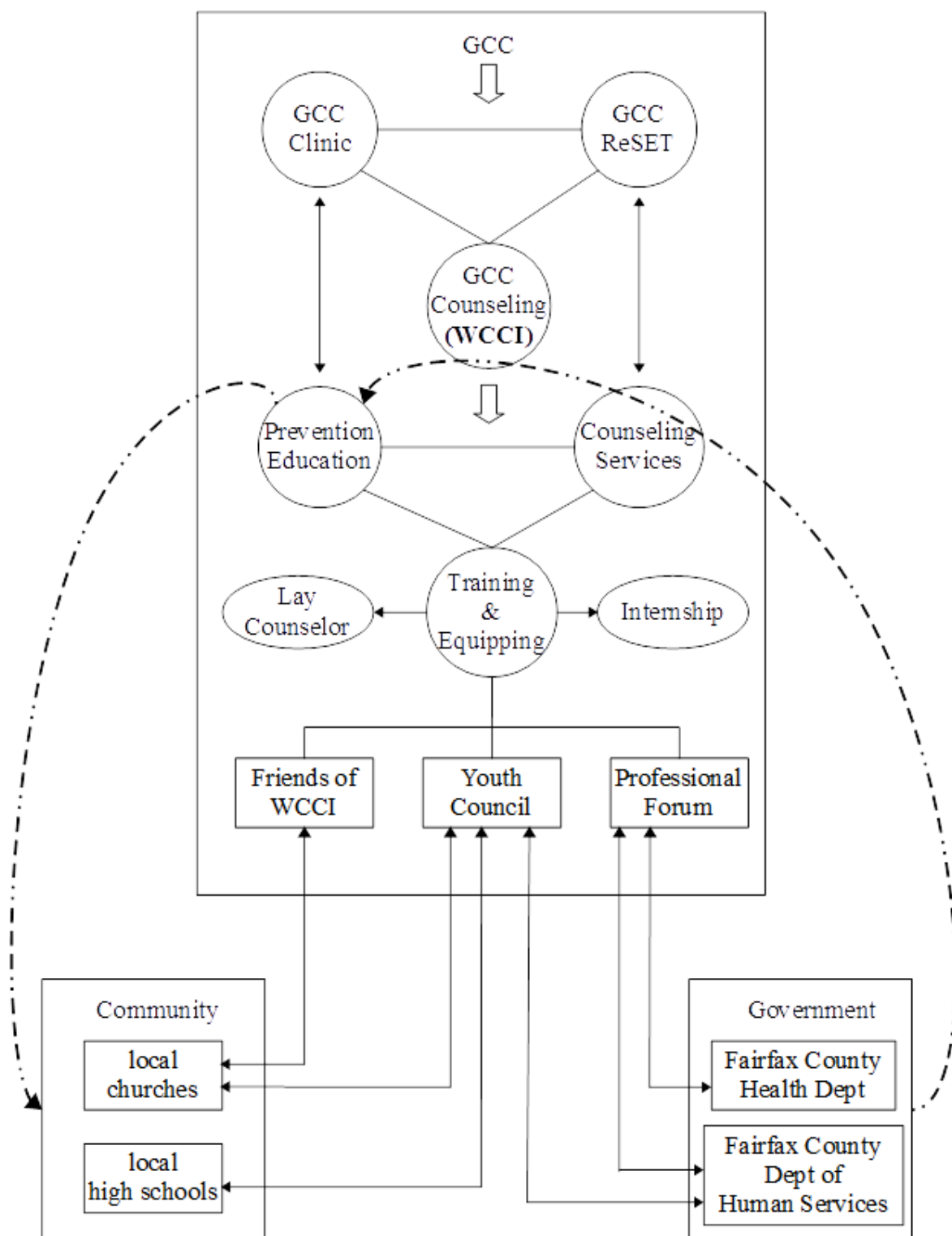
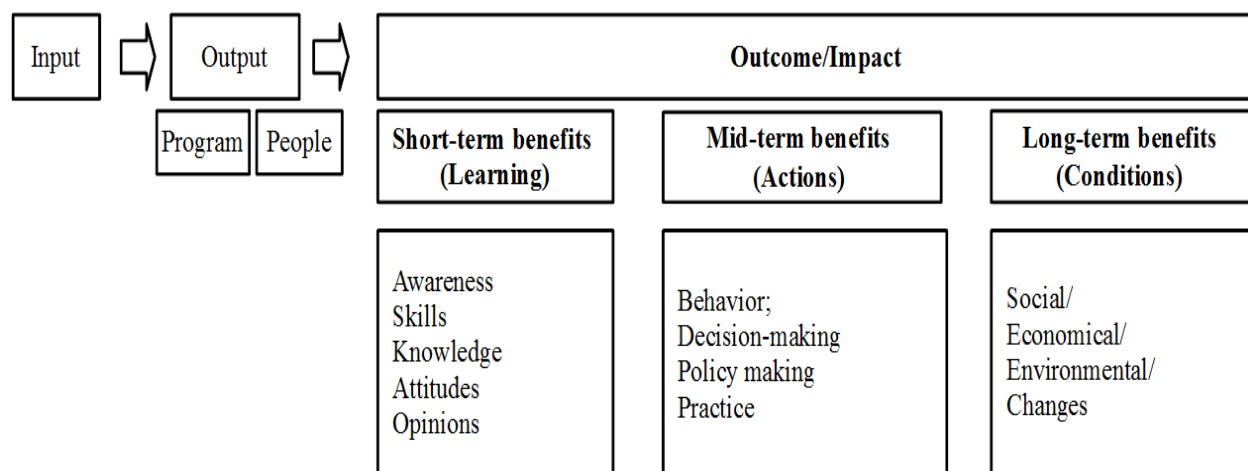


Figure 4.20. Overview of Intra and Inter-organizational Collaboration

### **People of WCCI**

Data collection and analysis on WCCI and its programs have been presented thus far using the framework of the logic model. WCCI's resources have been identified as inputs and its programs and participants have been identified and described as the outputs. Subsequently, the expected benefits and impact that programs have made on the participants are identified as the outcomes, which can be said to lie within the lives of the people involved with WCCI. In other words, the collective experiences of both the providers and program recipients can speak volumes to the meaningful outcomes of WCCI and the existence of its programs. The remaining description of this case study is dedicated to recounting some of the outcomes in the form of changed perceptions, actions, and conditions as experienced by program participants and are presented as they were expressed without any interpretation.

As stated in the beginning of this chapter, the logic models applied in this case study are utilized as a conceptual framework for identifying and describing, rather than for the purposes of planning, measuring, or evaluating programs. Therefore, descriptions of the outcomes are similarly guided by the logic model as it is used to guide the description of the resources, activities, and participants. In the foregoing, a brief demographical description of the participants (both service providers and recipients) and their motivations for participation are described. The participants' responses are then categorized and presented through the grid of "outcome" of the logic model as shown below in Figure 4.21.



*Figure 4.21. Logic Model of People's Lived Experiences*

### Description of Service Providers

WCCI is made up of volunteers with the exception of the executive director, and almost all of the service providers are bilingual and bicultural. The founder and the leadership of WCCI are all first-generation Korean American immigrants. They report that their immigration experience has had a significant impact on their reason for serving and that their personal experience of hardship during the period of adjusting to immigrant life compelled them to help others who are in need. One board member stated, "We are first-generation immigrants so we pay attention to other immigrants and their experience of suffering." Such sentiments are also reflected in the original intent of GCC founder Dr. Park: "We want to grow from being a minority group receiving help to being active contributors to the well-being of the community."

Faith is another primary reason that volunteers expressed as a compelling factor in their choosing to offer their services in various capacities. Dr. Park spoke of his desire to "share the love of God with the community through providing service to the underserved." Some also spoke of the times when they were discouraged because "the progress was slow," but the biblical command "to not become weary in doing good things" has spurred them on. The faith that

motivates the volunteers is shared across the board among all the people involved. Many spoke about being “called to serve.” Again, such sentiment reflects the original intent of the founder to honor God through sharing Christ’s love.

### **Description of Service Recipients**

Almost all of the program’s service recipients are foreign-born Korean Americans who immigrated to the U.S. in various stages of their lives. One notable exception is the members of the WCCI Youth Council, most of whom were born in the US. However, they too are heavily influenced in many ways by their first-generation immigrant parents. The service recipients can be categorized into three different groups. First are the Korean Americans who have participated in prevention education and training and equipping programs at WCCI as well as those who have received individual or family counseling services, most of whom have been first-generation immigrants. They responded to and utilized the services primarily because the services were offered in Korean.

Second, most who participate in the WCCI Professional Forum are 1.5-generation immigrants, those who were born in Korea but attended U.S. educational institutions for a significant part of their higher education. Many of them are bilingual and understand both Korean and mainstream American culture. Many of them acknowledged their unique qualifications and positioning to make a contribution to the betterment of the community and expressed their desire to do so. They also expressed frustration with the limited resources available to/for their non-English speaking and or low-income clients and expressed their appreciation for the opportunity to network.

Third, almost all of the WCCI Youth Council members are US-born second-generation Korean Americans. Many of them do speak Korean but are more comfortable speaking English,

so the services offered to them are conducted in English. They too have expressed their need for programs and services that take their unique cultural situation into account as this factor plays a significant role in their lives and the desire to be able to better navigate such issues in the two cultures in which they live. These various levels of English proficiency and cultural familiarity were reported to be relevant factors in seeking and utilizing WCCI programs.

### **Short-term Outcomes**

Short-term outcomes refer to the impact or benefits which result from the outputs which are the work that WCCI performs (i.e. programs and participants). In other words, the outcomes refer to the impact the programs had on the people involved. For example, raised awareness, skills developed, knowledge gained, and changed attitudes and opinions are all part of this outcome.

These short-term outcome learning objectives can then be translated into action-oriented midterm outcomes. The benefit of learning has been repeatedly identified and expressed by the participants. In fact, descriptions of improved awareness, knowledge, and skills as well as attitudes are the most frequently offered statements by the participants in this case study. For example, one participant Y. M. Kim who attended the very first Counseling Academy series for local Korean American church leaders in 2009 stated the following:

Attending the Counseling Academy, I got to look at my family of origin for the first time in my life... it was an eye-opening experience... I began learning about myself... every learning session was shocking... and I cried a lot. Even though I initially signed up to get training to equip myself as a small group leader at my church, it became for me a self-discovery. I really couldn't think about other

people. As the training progressed, I began experiencing compassion toward myself and others.

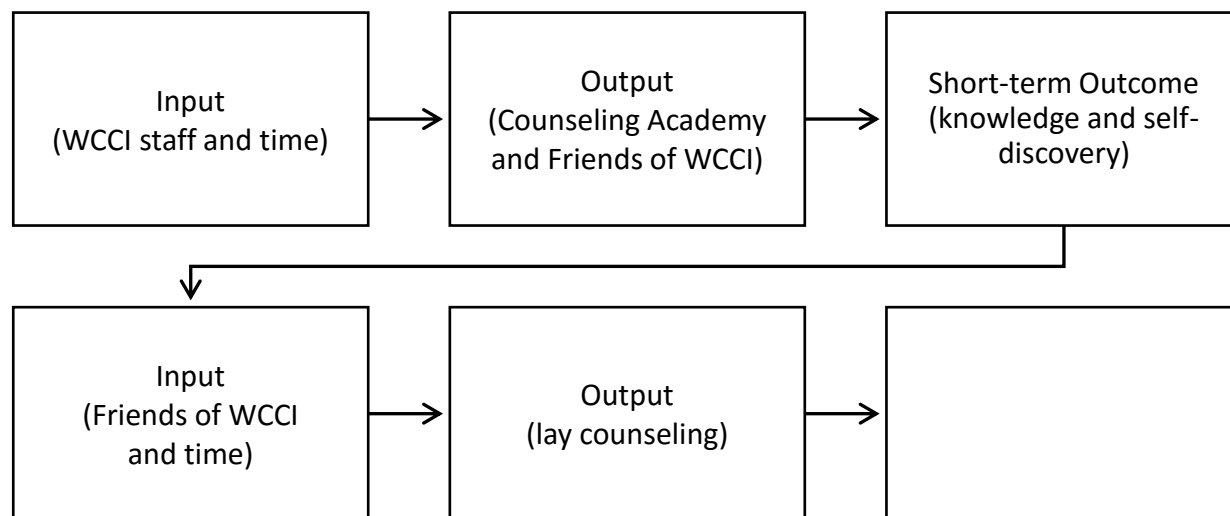
According to Y. M. Kim, her participation in the Counseling Academy became the catalyst for the formation of the Friends of WCCI with others who went through the same training and had similar experiences. She is still actively involved to this date and has taken on leadership roles both in counseling at her church and in joining the GCC board.

Mina, a member of the WCCI Youth Council, expresses similar sentiments. An excerpt from her interview reads,

I joined the WCCI Youth Council as a freshman when I was volunteering at the GCC Clinic and I am now a junior... it was my first exposure of any type of mental health program, especially involving Korean Americans... the lesson-style meetings over the past few years have helped... I remember a lot of stuff we talked about... it gave me knowledge of different mental health issues... it was eye-opening in the sense that it gave me a different perspective... it made me more sensitive, where before I would have joked about it... I am now more aware of myself and I am more equipped to help my friends if they come to me.

The impact of WCCI's training and equipping programs was expressed by many participants. As revealed in the above excerpts, participants have experienced greater self-awareness, greater sensitivity for others, the development of knowledge and skills and changes in attitudes and opinions. With regard to this aspect of development, WCCI executive director Dr. Kim said, "The first phase of equipping and training is focused on increasing self-discovery, while the second phase is devoted to equipping them to help others." He added that the Friends of WCCI group is a therapeutic small group made up of highly self-motivated individuals

seeking to learn and serve others, all of which together engenders a strong group cohesiveness. This is a prime example of the recursive process when the outcome as a result of the output (i.e. activities and participants) becomes the input (i.e. resources) which can then generate more output as illustrated in Figure 4.22 below.



*Figure 4.22. Recursive Process of Logic Model*

### **Mid-term Outcomes**

Mid-term outcomes refer to the impact or benefits that results from output (i.e. programs and participants) shown in the aspect of actions taken. It can include changes in the behavior of individuals, group norms, and choices made. These mid-term outcomes, which are action-oriented objectives, contribute to the long-term outcomes of changed social, economic, or environmental conditions in the greater community.

The benefits of increased self-awareness and awareness of others in relation to mental health issues have raised the level of mental health literacy in the areas of both knowledge and skills. This increased knowledge and skills reportedly results in changed behaviors in the participants' interaction with their families, friends, and fellow congregation members in their churches. Many spoke of how they have become better listeners and the ripple effects that their

own self-discovery had on their relationships with others. These self-reports were consistent with the report of executive director Dr. J. S. Kim, who noted that he had observed members of the Friends of WCCI becoming increasingly attuned to others in listening after a period of self-reflection and discovery.

Some service recipients became informal givers of the help that they have received through WCCI. One poignant example is provided below in the form of an excerpt from an interview with a participant who first received counseling, then participated in the Counseling Academy followed by a period of participation in the Friends of WCCI, and is currently involved in ReSET helping other women in difficult transition due to major life losses.

Researcher: How did you first get involved with WCCI?

Participant: It first started with my receiving individual counseling with a Korean-speaking Christian female counselor who is no longer there. Nine months later, my children and I began family counseling with another counselor who spoke both Korean and English because my children were more comfortable with English.

Researcher: I know you were also involved in the WCCI Counseling Academy. Tell me about that.

Participant: I received the Counseling Academy trainings I and II and then some continuing education sessions that followed... I then joined the Friends of WCCI.

Researcher: Tell me a little bit, without going into too much personal detail, about what you got out of the programs you have participated in with WCCI.

Participant: ...it was at two different stages, first when I was going through a difficult separation and divorce process... I was in total darkness... and I was very



emotional... I did not know myself, let alone fully understand the reality that I was in... it was a very, very difficult time and I had to do a lot of hard work in counseling for the first nine months... I cried in every session. Since it was Christian counseling, I had to confront my Christian beliefs and I had to work through my conflicts with my faith, and my relationship with God... my counselor guided me through all that... and there came a time when I finally understood and accepted my emotions... In the second stage, when I decided to attend the Counseling Academy, I wanted to understand the hurtful actions of the person who was most difficult to deal with at that time in my life. I wanted to see those things from a biblical or counselor's perspective, rather than being overtaken by negativity. If nothing else, I thought I could get a better idea of how to deal with difficult people. That was my goal.

Researcher: Did it turn out as you expected? How was the actual experience?

Participant: Half and half. I learned general practical knowledge that I could apply to any number of situations, while I gained more personal application through my individual counseling. I benefited from both but in different ways... I also learned from my peers in the academy... they were mostly leaders of some sort and seemed to have a sense of calling to care for people. As I observed them, I realized that, even though I had gone through counseling myself, I had not completely accepted the concept of the value of counseling... I still had some pre-conceived notions about counseling that were not hundred percent positive. As I participated in the activities of Friends of WCCI, though, any reservations I had

about the notion of counseling completely dissipated. The main gain was that I became a firm believer in people getting counseling.

Researcher: I understand that you are currently involved in GCC ReSET. How does all that you have gained through receiving individual and family counseling, attending the Counseling Academy, and participating in Friends of WCCI activities impact what you are doing right now in ReSET?

Participant: The person who has received the most benefit has been me... having received Christian counseling and education, it became possible for me to see myself and others from God's compassionate perspective... one day, I found myself in the stage of forgiveness... praying for the very person who hurt me... Having gone through the healing journey confronting my own thinking errors, I understand those in ReSET who are going through similar experiences right now... especially the ones who may be in abusive situations, I can see that they have difficulty seeing it for what it is... and have an incorrect understanding of counseling. Both in and outside of ReSET, I cross paths with many who are in need of counseling and I encourage them... I make referrals, I point them to resources, and I share my stories...

It should be noted that many of the women who are currently active in ReSET have also benefited from participating in WCCI programs such as counseling and mental health education. WCCI and its programs have changed the way people seek help or make referrals. As briefly mentioned in the above dialogue, Friends of WCCI has been a referral source, a vehicle for Korean American community members to access WCCI's counseling services. In fact, more

frequently than pastoral referral, referrals from members of Friends of WCCI have been very effective in getting people who are in need to seek and accept help.

According to executive director Dr. Kim, this point provides the following insights. First, people are more comfortable with informal referrals. Second, some may not feel free to open up to an authority figure such as a pastor. Therefore, WCCI's effectiveness may affirm the parachurch counseling ministry model and the need for a strong lay counseling ministry. In short, raised awareness and knowledge and skills acquired along with changed attitudes about mental health issues seem to be translating into concrete actions as described above, be it via serving, making referrals, or practicing forgiveness.

### **Long-term Outcomes**

The long-term outcomes refer to the changed conditions on a macro-level such as the social, economic, and environmental levels. It is difficult to provide a macro-level description of change with any validity or reliability based solely on individual feedback and observations since each individual can only speak for him or herself. The extent of the long-term outcome on a community level can only be assumed from the accumulated benefits experienced and expressed by the individuals involved with WCCI and its programs. To truly and accurately describe and understand the outcomes at this level, a separate study needs to take place using sample populations and evaluation instruments, a task which is beyond the scope of this case study.

In this case study, the long-term outcomes are described in the form of what is hoped and imagined to be achieved for the greater community in the minds of people who are involved through WCCI. Some of the expressed hope and expected outcomes on the larger community level are as follows.

WCCI Youth Council member Mina identifies the continuing need at the community level: For Korean Americans, mental health is still not an important topic... it's shunned... you have to deal with it on your own... especially our parents' generation... I wish you can do what the WCCI Youth Council did (referring to the youth-led mental health stigma reduction project) with Korean American adults too.

Even though much progress has been made in raising awareness, there seems to be recognition that Korean Americans as a community still need to do more.

The director of ReSET also has hopes to continue efforts to increase the community's sensitivity toward special populations whom otherwise may be marginalized by adding a support group for widowers in the future, following in the footsteps of the current single women's group supporting each other through major life losses and transitions. As indicated by the aforementioned statements, the community is clearly in the mind of the individuals.

The work of WCCI has the potential to reach the greater community beyond the boundaries of the Korean American community. Young M. Kim who started Friends of WCCI and has been an active participant of WCCI, points out,

Members of Friends of WCCI are embedded at all levels of the community in all different areas of work... so WCCI is impacting not only the individuals but also their churches, organizations, and other social arenas... We want to make a difference in correcting the view of marriage and more.

GCC board secretary Young Gil Kwon also said, "The board's intention is that the organization would benefit the larger community beyond the walls of each church." Such sentiments align with the original vision statement of the organization.

### Summary of Data Analysis

The question “Why (motivation; what gave rise to...)” has been briefly mentioned as it pertained to the volunteers. However, a set of answers to the “why” questions exists for the program recipients. In the section that follows, the reasons for which volunteers participated in the organization and its programs are considered in order to make a causal relationship with the identified needs. The identified needs and the service gap propelled the process of investing resources and running the programs. The outcome is the reward for all people who invest their time and energy, as it shows what difference it makes for the lives of people involved. Together the service providers and recipients make WCCI and its programs meaningful. This entire process is illustrated in Figure 4.23 below.

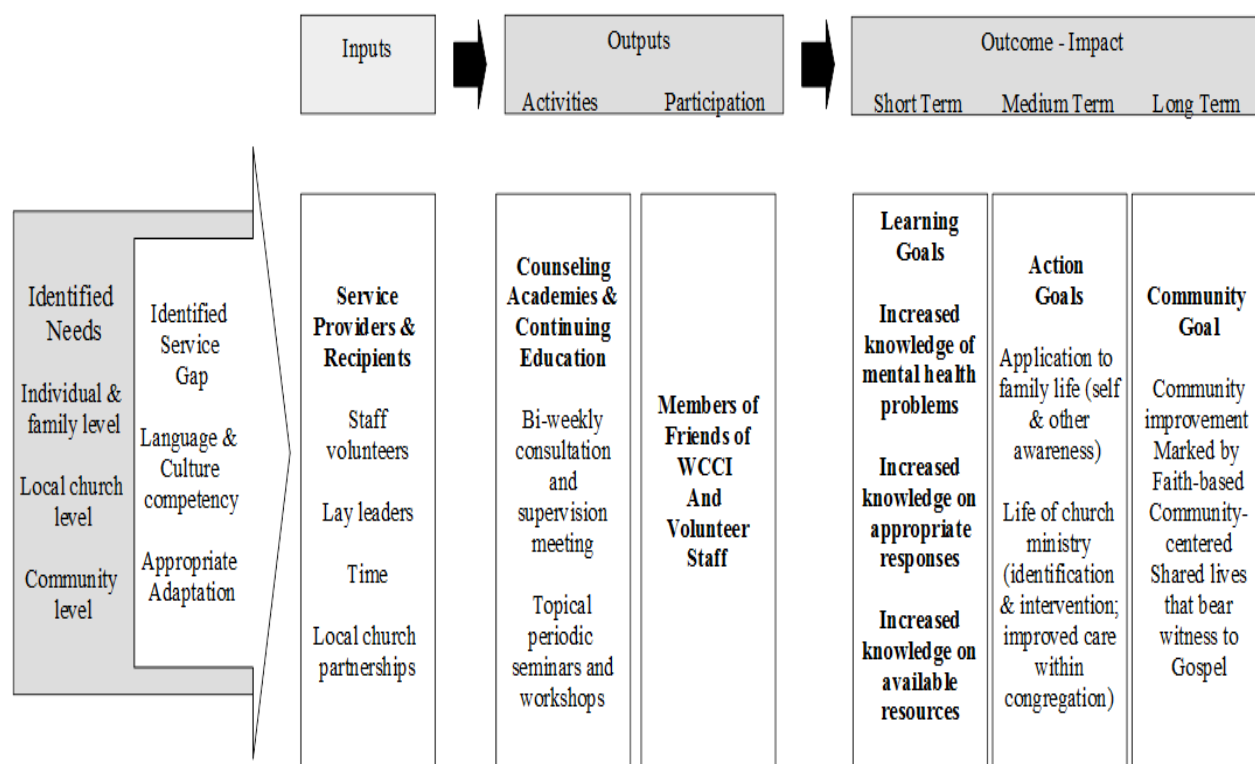


Figure 4.23. Logic Model of People's Lived Experiences

### **Summary**

This descriptive case study began with a description of the umbrella organization GCC, a health and human services nonprofit organization. It then focused its description on WCCI, a subsystem of the umbrella organization GCC. WCCI's programs were first described, including the areas of prevention education for the general public, training and equipping programs for professional and lay counselors, and the provision of clinical counseling services. Second, WCCI's focus groups were described – Friends of WCCI, the WCCI Youth Council, and the WCCI Professional Forum. Finally, a description of the people involved in the organization and its programs, with contributions from key GCC and WCCI informants, was provided.

Brief descriptions of the other subsystems (GCC Clinic and ReSET) under the umbrella of GCC were provided mainly to provide the broader context of GCC. Detailed examinations of these subsystems may be of future interest since the GCC Clinic and ReSET have each evolved in their own ways to serve the community.

The scope and depth of the description in this case study has largely sought to highlight WCCI, its programs, and the people involved. In addition, the interconnectivity and interdependence between the various subsystems within and outside of WCCI have been described. In doing so, two important constructs to this case study - collaboration and integration - have been described and illustrated, allowing the research questions to be answered. In reviewing the research questions, there are four parts to the original inquiry: 1) how the organization functions (i.e. financing, staffing, and practicing), 2) what the programs are; what the purposes and objectives of each program are; and how the programs are formed and structured, 3) who is involved including providers and recipients; what the responses of those

involved are, and 4) what theoretical construct is helpful in understanding why the organization works or how it works. The first three sets of questions have been addressed under the categories of the organization, its programs, and its people. The fourth and the last part of the research question has been answered throughout but especially in the sections devoted to the description of WCCI's operational strategy.

Each descriptive category is laid out against the backdrop of another category. This means of categorizing was used to organize the data from which many separate future case studies can be composed, allowing each category to be the single focus of a case.

## **CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS**

### **Introduction**

The 2010 Census Brief (U.S.Census Bureau, 2012) reports that, from 2000 to 2010, the U.S. Asian population grew four times faster than did the total U.S. population, at a rate of 43% versus 9.7%. On a local level, Fairfax County in northern Virginia (where this research case is nested) reported the largest racial/ethnic minority group to be Asian Americans, making up 18% of the total population in the region (PolicyLink & PERE, 2015), with Korean Americans and Asian Indians making up the largest share of the county's Asian American population. Therefore, it can be said that the well-being of the Korean American immigrant community in this region holds significant implications for the future of public health and mental health issues in the area.

Despite the ever-increasing diversity in the U.S. as a whole and the rapid growth of Asian groups such as Korean Americans in the Washington, D.C. metropolitan area, the resources available to meet the needs of these underserved immigrant populations are limited. Consequently, little to no provision has been made for equitable access to mental health-related care to those who need linguistically compatible and culturally well-informed mental health services. In response, the present case study was conducted to gain insight into how to facilitate the provision of such services to the Korean American immigrant community in the Washington, D.C. metropolitan area through the investigation and description of the ethnically-tailored, community-centered, faith-based nonprofit mental health system of WCCI.



This case study set out to investigate and understand how the services WCCI offers address the mental health needs of the Korean American immigrant community in the Washington, D.C. metropolitan area. The research questions were divided into the following four parts: 1) organization (system and sub-systems); 2) programs; 3) people involved; and 4) important/innovative constructs such as unique approaches to addressing the unmet mental health care needs of this particular minority group.

In Chapter Four, the present case study results were provided. Descriptions corresponding to the research questions mentioned above were provided in the order of the following: WCCI within the context of the umbrella organization GCC; the programs WCCI offers; the people involved including both service providers and recipients; and some of the key constructs in the innovative approach employed by WCCI. In this chapter, a summary of the key findings in each of the categories and with their implications and limitations are presented along with recommendations for future research.

### **Key Findings**

A service delivery model that is community-centered, linguistically compatible and culturally sensitive and informed can be effective.

#### **Research Question Part I: Organization (Research Question #1)**

Both in-depth interviews and record reviews have provided the answers to the research questions pertaining to the organization: How does the organization function (including financing, staffing, and practice)?

1. The birth of WCCI was prompted by the unmet needs of a particular community. In other words, WCCI was born out of the identified community needs.

2. WCCI's vision and mission were based upon Christian principles and applied for the good of underserved communities.
3. The structure of WCCI evolved over the years according to the identification of new additional needs rather than according to the implementation of a development plan. It should be noted that WCCI's system was open and flexible, which enabled it to respond to and incorporate emerging needs for expanded services.
4. WCCI is strategically located within the neighborhood which it seeks to serve, allowing easy access to its services by those in need.
5. WCCI has self-sustaining measures of financial, physical, and human resources. A mixture of largely private funding (e.g. contributions from local churches, fundraising within the community, and individual/group support) and some limited governmental funding are available for WCCI. It should be noted that the impetus for limiting the organization's reliance on government funding is in accordance with the purpose of maintaining program independence.
6. A network of local churches and their leaders play an important role in maintaining WCCI and its programs as faith-integrated services. This emphasis on maintaining a faith-based approach applies not only to program content but also to the development and implementation of the program's administrative oversight and functioning.
7. While WCCI allows a high degree of autonomy on a sub-system level, the system and sub-systems voluntarily enjoy and support a high degree of interdependence. Therefore, both inter-organizational and intra-organizational working relationships are characterized by mutual interdependence.

## **Research Question Part II: Programs (Research Question #2, 3, & 4)**

In-depth interviews, observations and record reviews provided the answers to the research questions pertaining the programs: What programs are in existence? What are the purposes and objectives of each program? How are the programs formed, structured and operated?

**Individual/family counseling.** The culturally sensitive, linguistically compatible, faith-integrated services provided by WCCI are invaluable because most individuals and families served by WCCI are unable to seek out mainstream services or gain access to them due to linguistic and cultural barriers or lack of knowledge of such resources. Linguistic competency plays a key role in the therapeutic processes as the success of such services depends heavily on language and one's ability and freedom to express oneself in the language in which the services are provided.

**Training and equipping.** Lay counselors are trained to adapt to cultural particulars such as 1) help seeking via informal routes, and 2) the church as a platform for faith and as a social comfort zone for many immigrant families. Programs that offer a platform for internship in order to assist future skilled and culturally informed mental health professionals are of great benefit as well.

**Community education.** Prevention education for local church congregations and the general public reaches many people and provides non-directive help to those who may be unsure as to how to deal with mental health-related difficulties they may experience themselves or via family members. In general, there is a high degree of cultural adaptation in the delivery mode (i.e. the psychoeducational format of delivery) used in order to maximize the effectiveness of the services provided. For example, reducing stigmas through psychoeducational prevention

programs is an example of adaptation to the cultural emphasis of Korean Americans on education, wherein education has highly positive associations.

A high degree of inter-organizational collaboration allows WCCI to offer a large variety of mental health-related programs to the service recipients while minimizing the utilization of WCCI's own resources (i.e. PIPF programming).

Fiscal accountability largely occurs at the organization level; however, procedural or process accountability is lacking due to the absence of a formal mechanism for evaluation (i.e. efficiency) at the program level. Similarly, performance measurement or evaluation (i.e. quality control) is lacking for the same reason. Thus there is room for the organization's record keeping to be strengthened. In general, having an accountability and feedback system would help create an enduring history of the organization that would help carry the organization through periods of challenge in the future.

The three focus groups of WCCI also play pivotal roles in the organization. Through the Friends of WCCI, connections and collaboration with area congregations is promoted, while the work of the WCCI Youth Council in providing mental health education to young people incorporates the Korean American cultural value of early education. Through the WCCI Professional Forum, a sense of social responsibility among Korean American professionals is fostered. In the aforementioned programs, the different focus groups share physical, financial, and human resources.

### **Research Question Part III: People - Service Providers and Recipients (Research Question #5 & #6)**

Both in-depth interviews and observations have provided answers to the questions pertaining the people involved in WCCI - the service providers and recipients: Who is involved, including providers and recipients, and what are their responses?

WCCI and its programs are largely run by volunteer staff. The distinction between providers and recipients of services is soft and fluid in that many recipients in turn serve with the service providers/staff. In addition, all service providers/staff voluntarily participate in WCCI and are motivated to do so based on their adherence to core Christian values (i.e. serving one another as all being a part of one body) and an affirmed sense of calling.

The working relationships among the WCCI workers are characterized by a high level of trust and respect, evidenced by the consensus created by the round-table discussion decision making process. These relationships are also grounded in biblical principles (e.g. serving one another, building up the body, and excellence in ministry for God's glory), resulting in mutual respect and admiration among WCCI's workers and a spirit of unity. Therefore, there is little to no evidence in WCCI of relational conflicts that commonly plague such service organizations.

Furthermore, the variety of individuals in different life stages that are involved in WCCI provide for unique contributions from diverse perspectives and facilitates a fluidity that allows for individuals to both maximally impact and be impacted by one another. This sense of community is strengthened by the mutual benefit of belonging to and learning from one another in mutual support.

#### **Research Question Part IV: Salient Constructs (Research Question #7)**

What theoretical construct is helpful in understanding why the organization works or how it works? Several salient key elements are at work at WCCI that are consistent across both the personal and program levels. The culture of collaboration, integration, and adaptation that mark the organization's operations are one of its unique strengths.

The collaboration and integration that occurs within WCCI are both multi-level, multi-sectoral, and multi-directional. Such cooperation is comprehensive and includes intra- and inter-agency collaboration, intergenerational collaboration, and collaboration between lay people and professionals. In addition, the spirit of respect and trust necessary to facilitate such collaboration and adaptation in the interest of meeting others' needs is solid and stable because of its grounding in Christian values. The cultural tendency of Korean Americans to emphasize hierarchy is largely absent from the culture of WCCI. Rather, humility and servant leadership are exemplified and have proven to be effective in facilitating the accomplishment of WCCI's goals, as is demonstrated by the vibrant engagement of the community in all levels of the organization.

#### **Conclusions**

The results of this case study suggest that a mental health service delivery model with certain constructs such as multi-directional collaboration, multi-dimensional integration, a uniquely educational and preventive approach, culturally sensitive adaptations, and a grounding in faith values can be highly effective in meeting the needs of ethnic minority immigrant communities. The system of mental health care in this case study seeks to incorporate the priorities of being an ethnically-tailored, community-centered, faith-based service provider. This

service model is multi-dimensional in many ways to meet the needs of the Korean American immigrant community.

It is worth noting that the successful service delivery model of WCCI addresses the issues raised in the report made during the Virginia Health Care Foundation's Mental Health Roundtable held in May 2009. The report (which was on ethnic mental health disparities) identified the key disparities as "access to quality services; help seeking and help utilization; negative experiences within system; pervasiveness of stigma; lack of language and cultural competency among practitioners; lack of inclusion in research and clinical trials" (Chesser, 2009). With the exception of the last item (inclusion in research and clinical trials), WCCI's service delivery model responds to all of these disparities.

It is also worth noting that the U.S. Department of Health and Human Services Office of Minority Health established the Center for Linguistic and Cultural Competency in Health Care (CLCCHC) to address issues related to health disparities for populations that speak limited English. The purpose of the CLCCHC is to promote equitable and effective health care service delivery that is "linguistically appropriate and culturally competent" to limited English-speaking populations (U.S. Department of Health & Human Services Office of Minority Health, 2010). Subsequently, the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care, known as the National CLAS Standards, were first published in 2000. These were followed by the launching of the National CLAS Standards Enhancement Initiative by the Office of Minority Health in 2010 in order to ensure the implementation of CLAS at various organizational levels. Its principal standard is to "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural

health beliefs and practices, preferred languages, health literacy and other communication needs” (U.S. Department of Health & Human Services Office of Minority Health, 2010).

In view of the National CLAS Standards (Appendix A), the findings from this case study are in concert with the spirit of these standards. These findings also point to guiding principles, as laid out in the key findings above, which can help to create and maintain a mental health service delivery for underserved ethnic minority communities that is ethnically tailored, community centered, and faith based. Therefore, the guiding principles distilled from the findings of this case study include the following:

1. Empower and utilize community resources, be they physical, financial, or human resources, including language capacity.
2. Affirm and utilize the strengths that reside within the community (e.g. intergenerational relationships, sense of cohesiveness). The collaborative care that takes place vertically (inter-generational) and horizontally (varying degrees of assimilation according to the length of immigrant life) is a unique strength that immigrant minority communities have. Preserving it and enhancing it would do well for the community.
3. Allow faith to be the compelling and driving force for services rendered and received. As evidenced by findings in the literature and this case study, the integration of faith is a way of coping and living as well as being part of society in a meaningful way for many immigrant minority populations.

## **Implications**

The implications of the findings of this case study for communities of similar cultural backgrounds point to ways to improve upon the current underutilization of mental health services by Asian American minorities seen in numerous studies. That is, if and when there are mental



health delivery services available that are ethnically tailored, community centered, and faith based as are those provided by WCCI, there can be a vibrant, engaged community of service providers and recipients. This is consistent with research findings that Asian Americans do indeed utilize ethnicity-specific programs at a higher rate than mainstream services when such services are made available to them (Lin, 2011; Mier et al., 2010; Ziguras et al., 2003).

The following discussion of the implications of this study's findings may also serve the needs of health care system leaders, nonprofits, local governments and policymakers well, if considered when engaging underserved ethnic immigrant minority communities.

**Collaborative care.** As mentioned in the literature review, there exist several collaborative care models to meet the mental health needs of immigrant communities, including the Montgomery Cares Behavioral Health Program (MCBHP) (Kaltman et al., 2011). The MCBHP is reported to be a successful adaptation of the evidence-based model of traditional collaborative care in that it provides mental health treatment in a primary health care setting. However, unlike the MCBHP, the multi-level system of collaborative care practiced at WCCI is a comprehensive collaboration. It not only promotes collaboration of physical and psychological care, it also incorporates intra- and inter-organizational collaboration. Furthermore, within the intra-systemic collaborations, the intergenerational collaboration that also occurs is highly effective and unique to ethnic immigrant communities like Korean Americans. The language and cultural barriers frequently mentioned in literature pertaining to health disparities for minorities (Garland et al., 2005; Laraque & Szilagyi, 2009; S. Lee et al., 2009; S. Lee et al., 2011; Le Meyer et al., 2009; Lin, 2011; Lo et al., 2014; Miranda et al., 2002) are nicely resolved via strong intergenerational collaboration. First generation and second generation immigrants can be served by the "1.5 generation" (members of the WCCI Professional Forum in the case of

WCCI) who can act as a broker between the old and new culture utilizing their mastery of both languages.

This has implications for communities of similar cultures where many of the resources needed can be sourced from within the community. The implication of WCCI's unique approach to service delivery suggests that these additional elements speak to the value of collaborative care models.

**Integrative care.** Some of the studies presented in Chapter Two point out that taking a collaborative care approach to providing mental health services in conjunction with primary medical care is described as an integrative model, integrating general medical and behavioral health care (Smith et al., 2013). According to a U.S. Department of Health and Human Services news release from October 14<sup>th</sup>, 2015, the agency announced the provision of over \$240 million to expand the primary care workforce and connect health care professionals to underserved communities in order to increase access to primary health care in communities that need it most (U.S. Department of Health & Human Services News Release, 2015). Unfortunately, the funding is provided mainly to primary care clinicians and students in exchange for their service in underserved communities, with no specific provisions for mental health care. Such trends in funding point to a greater need for the explicit integration of mental health care that collaborates with the primary care environment, especially for underserved communities.

Therefore, again WCCI's unique approach to service delivery suggests additional elements to augment the integrative care model, as seen in the social and spiritual care provided through programs like ReSET. Regarding the integration of physical and psychological care, it should be noted that even though WCCI does not currently coordinate and share service

recipients with the GCC Clinic, the effort to provide both physical and mental health care under one roof as part of an intra-agency collaborative effort is a good practice in general.

This setup also has implications. At a minimum, it could indicate the future direction of WCCI towards incorporating those Korean American primary care recipients currently being served through the GCC Clinic at the church location into a system of better coordinated mental health care on site. Furthermore, the integrated model of bio-psycho-social-oriented care seen in this case study has implications when applied to communities of similar cultures, as it provides comprehensive and holistic care.

Finally, an additional important distinction needs to be made regarding integrated mental health care. As stated above, the integration of care at WCCI is much broader and more comprehensive than that which might exist at the level of a single service provider. Because the Christian faith is integrated into the fabric of WCCI both at the micro and macro levels, integration occurs not only at the content level but also at the organizational level as WCCI interacts with local Korean American churches. Cultural aspects such as the strong emphasis on education are also integrated into the functioning of WCCI towards its service recipients, making the difficult subject matter of mental health more user friendly and palatable. Thus the integration that occurs at WCCI is multi-faceted and includes the aspects of faith and culture, which is relevant and applicable to other communities of similar cultural backgrounds.

**Alternative care.** It is important that the alternative mental health care model discussed in the literature review be brought forth again in the light of WCCI's practice. As previously discussed, alternative mental health centers are unlike their public community mental health center counterparts in that, rather than functioning under federal, state, and or local government regulations, they are non-profit agencies born out of a response to perceived unmet needs in a

particular community (Lafollette & Pilisuk, 1981). Table 5.1 below presents some key characteristics of such alternative mental health clinics.

Table 5.1

*Characteristics of Alternative Mental Health Services*

Service model	Pragmatic, eclectic, holistic and client-focused Wide range of treatment modalities employed Auxiliary services related to housing and employment sometimes included Lack of quality control
Relation to local government	No official ties to governmental authority Financially supported by individuals and private foundations
Composition and function of the board	Little distinction between consumers and providers of services/board members Largely run by volunteer staff
Funding	Mixture of largely private funding with some limited governmental funding in order to maintain program independence

In the present case study, WCCI sought to help the Korean American immigrant community by meeting identified needs which were not being met through existing public mental health services. Therefore, the service delivery model that evolved in the organization and with the people of WCCI can be said to have incorporated this alternative care model. Again, it should be noted that such an approach was not planned and implemented, but rather naturally evolved.

As such, the development of WCCI's unique approach to service delivery as a response to emergent needs in the Korean American community may serve as an example for consonant work in communities of similar cultures. Therefore, it holds implications for communities of similar cultures where emerging needs are identified as people adjust to and assimilate into the mainstream culture.

**Faith-based and community-centered care.** At present, the federal government is increasingly making efforts to acknowledge the importance of engaging faith-based nonprofit organizations and community organizations. One such effort is the U.S. Department Health and Human Services' Partnership Center, which functions as a liaison between the U.S. government and grassroots organizations (<http://www.hhs.gov/about/agencies/iea/partnerships/about-the-partnership-center/>). Organization like GCC and WCCI will play an important role in the government's effort to reach out to underserved communities such as ethnic minority immigrant communities and ensure equitable access to mental health care for such populations. Therefore, the work WCCI does has significant implications for similar work among other communities of similar characteristics and needs, as well as further implications for the public health of society in general.

### **Limitations**

The initial assumption of this study was that an ethnically-tailored, community-centered, faith-based service delivery model is an innovative approach and viable option for meeting the mental health needs of the Korean American immigrant community. The case study of WCCI and its programs and people demonstrated that indeed such a model can facilitate the vibrant engagement of the community, of both service providers and recipients, and improve the accessibility and utilization of mental health services by an otherwise underserved community.

Nonetheless, there are some limitations to this present case study. First, the findings of the study may apply only to this specific Korean American immigrant community and this specific region of the Washington, D.C. metropolitan area. It is possible that Korean American immigrant communities elsewhere may present different kinds of needs and require different

levels of resources to meet the needs of its people, thus limiting the general applicability of this study to the spectrum of needs experienced by Korean American immigrant communities beyond the Washington, D.C. metropolitan area. This could also be the case with regard to other ethnic immigrant communities, thus limiting the extent to which useful generalizations may be made based on the findings of this study. Second, the study's applicability may be limited by the particularities of the study's participants that influence their experience of the programs. These are external factors that can limit or change the outcome or impact the organization and its programs can have on individuals, and thus may limit the generalization of this study's findings.

Regardless of such concerns, the fundamental need for understanding and expressing one's struggles and the need to process them with someone who can accurately understand and empathize with them is undeniable, regardless of what the struggles may be. Therefore, the development of any program model that promotes efforts to reduce barriers to mental health service utilization by non-English speaking minority immigrant communities is a worthwhile effort. Furthermore, the broad concept of community-centered adaption and providing mental health services that are culturally well-informed and linguistically compatible is at a minimum moving in the right direction toward the equitable benefit of providing more effective mental health services.

### **Recommendations for Future Research**

This case study focused on WCCI and provided only a brief description of a bird's eye view of the entire system in which WCCI is nested. Therefore, future research may be devoted to any specific service area or program contained therein. Future research may also focus on a specific group of people within WCCI's many programs. In short, numerous avenues exist for

further study within the multi-faceted diversity of people and dynamics at work in the organization.

Future research may also be devoted to implementing a comprehensive outcome-based performance management and evaluation of the system in order to promote accountability (Xu & Morgan, 2012) and may facilitate further inquiries. For example, the extent of the long-term outcomes on a community level can be a separate study that takes place using sample populations and evaluation instruments, which was a task beyond the scope of this case study.

### **Summary**

In this chapter, a summary of the key findings in each of the categories corresponding to the four categories of research questions was first provided. Secondly, conclusions were reached as to the guiding principles that were distilled from those findings. Thirdly, the practical implications of the key findings for communities of similar cultural backgrounds were discussed in detail. Finally, the limitations in generalizing the key findings of the case were mentioned, followed by a few brief recommendations for further research on the subject matter.

In reviewing the present case study in its entirety, the following comprehensive summary can be offered:

First, the stresses of immigrant life are especially acute for non-English speaking minorities such as Korean Americans, many of whom have immigrated to the U.S. within the past 30 years. Despite the fact that such stresses lead to a particular vulnerability to mental health problems, Korean American immigrants are unable to utilize mainstream mental health services due to cultural and language difficulties.

Second, the literature review indicated that, although some efforts have been made to reduce the mental health disparities faced by minorities, both individual and contextual barriers impede the aforementioned populations from seeking and receiving mental health services, with no concrete model having been presented to resolve this issue. In fact, the limited literature available on this matter consisted primarily of theoretical knowledge and seriously lacked connection to practical application and/or implementation, leaving a significant gap between theory and practice.

Therefore, in view of the unmet needs for mental health services among non-English speaking minorities such as Korean Americans, the need to identify and develop an effective mental health service delivery model was imperative in order to better serve the rapidly increasing Korean American immigrant communities.

To that end, the present descriptive case study was conducted for the purpose of investigating and explaining the mental health-related services of WCCI in the Washington, D.C. metropolitan area. WCCI's innovative culturally-informed, language-specific, and community-based approach was examined to determine if it could serve as a viable model of service delivery. The methodological details included purposeful selection of participants and three sources of data collection were employed - interviews, observations, and documents.

The result of this case study rendered a description that began with the umbrella organization GCC, within which the mental health subsystem WCCI is embedded. WCCI and its programs were then described, followed by a description of WCCI's focus groups. Finally, descriptions of the people involved in the organization, both service providers and recipients, were provided. Most importantly, the constructs of multi-dimensional collaboration and integration at work in WCCI's operational strategy have been described and illustrated. As such,



the research questions have been answered. The first three groups of research questions have been addressed under the categories of the organization, its programs, and its people. Those research questions belonging to the fourth and final portion of the set have been answered throughout, but were addressed in greatest detail in the sections devoted to the description of WCCI's operational strategy.

In conclusion, certain guiding principles distilled from the key findings of this case study can be drawn, which not only reflect how and why WCCI works, but also paint a picture of a viable model of mental health service delivery for other immigrant ethnic minority communities of similar cultures. Therefore, an improvement upon the current underutilization of mental health services by such groups can be made. Although the degree to which the findings can be generalized may be limited, this case study was well worth the effort, considering the lessons learned from it. Furthermore, the prospect of future research possibilities on the subject matter and the potential benefits of the conclusions drawn from this study offer much hope for establishing similar services for many currently underserved communities.

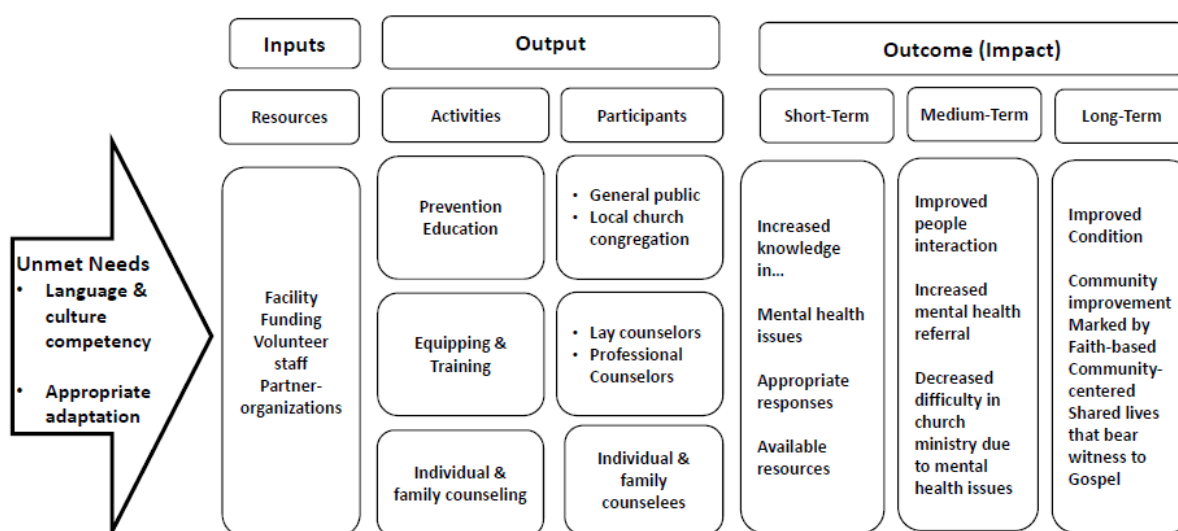


Figure 5.1. Exportable Service Delivery Model

## REFERENCES

- Ahn, D. (2013). *Perceptions of mental illness and attitude toward seeking professional psychological help among Korean clergymen in America*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3553211 Psy.D.)
- Akutsu, P. D., Snowden, L. R., & Organista, K. C. (1996). Referral patterns in ethnic-specific and mainstream programs for ethnic minorities and Whites. *Journal of Counseling Psychology*, 43(1), 56-64. doi: 10.1037/0022-0167.43.1.56
- Antoniades, J., Mazza, D., & Brijnath, B. (2014). Efficacy of depression treatments for immigrant patients: Results from a systematic review. *BMC Psychiatry*, 14(176). doi: 10.1186/1471-244X-14-176
- Barreto, R. M., & Segal, S. P. (2005). Use of mental health services by Asian Americans. *Psychiatric Services*, 56(6), 746-748.
- Barton, A. K. (1978). A problem, policy, program model for planning community mental health services. *Journal of Community Psychology*, 6(1), 37-41.
- Bernstein, K., Chen, D., & Bang, H. (2013). Cognitive interviewing to develop a mental health services barrier assessment. *Journal of Theory Construction & Testing*, 17(1), 4-10.
- Bernstein, K. S. (2007). Mental health issues among urban Korean American immigrants. *Journal of Transcultural Nursing*, 18(2), 175-180. doi: 10.1177/1043659606298610
- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, 109(4), 243-258. doi: 10.1046/j.0001-690X.2003.00246.x
- Cheung, M., Leung, P., & Cheung, A. (2011). Depressive symptoms and help-seeking behaviors among Korean Americans. *International Journal of Social Welfare*, 20(4), 421-429. doi: 10.1111/j.1468-2397.2010.00764.x
- Chesser, M. (2009). *Study on disparities in minority mental health* [PowerPoint slides].
- Choi-Kim, G. (2009). *Congregation as a healing community: A framework of a systematic approach to Christian education for Korean American women*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3356203)
- Choi, H. (2001). Cultural marginality: A concept analysis with implications for immigrant adolescents. *Issues in Comprehensive Pediatric Nursing*, 24(3), 193-206.
- Choi, S. S. (2013). *Barriers to professional help-seeking among Korean Americans: Acculturation, stigma, and attitudes*. Retrieved from ProQuest Dissertations & Theses database. (3604921)

- Chu, J. P., & Sue, S. (2011). Asian American mental health: What we know and what we don't know. *Online Readings in Psychology and Culture*, 3(1), <http://dx.doi.org/10.9707/2307-0919.1026>.
- Coker, T. R., Elliott, M. N., Kataoka, S., Schwebel, D. C., Mrug, S., Grunbaum, J. A., . . . Schuster, M. A. (2009). Racial/ethnic disparities in the mental health care utilization of fifth grade children. *Academic Pediatrics*, 9(2), 89-96. doi: 10.1016/j.acap.2008.11.007
- Connor, P. C. (2010). *A theory of immigrant religious adaptation: Disruption, assimilation, and facilitation*. Retrieved from ProQuest Dissertations & Theses database. (3410990)
- Corrigan, P. W. (2012). Research and the elimination of the stigma of mental illness. *The British Journal of Psychiatry*, 201, 7-8. doi: 10.1192/bjp.bp.1111.103382.
- Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., . . . Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27(2), 187-195.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage (Original work published 1998).
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage
- Creswell, J. W. (2013). *Qualitative inquiry and research design : Choosing among five approaches* (3rd ed.). Los Angeles: SAGE Publications.
- Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007). Help-seeking and access to mental health care in a university student population. *Medical Care*, 45(7), 594-601. doi: 10.2307/40221479
- Evans, E., Pierce, J., Li, L., Rawson, R., & Hser, Y.-I. (2012). More alike than different: Health needs, services utilization, and outcomes of Asian American and Pacific Islander (AAPI) populations treated for substance use disorders. *Journal of Ethnicity in Substance Abuse*, 11(4), 318-338. doi: 10.1080/15332640.2012.735172
- Virginia, Fairfax County (2015). Partners in prevention Fund (PIPF). Retrieved from <http://www.fairfaxcounty.gov/ncs/prevention/pipf.htm>
- Finch, E. S. (1986). *Psychiatric rehabilitation outside the bureaucracy: A naturalistic study of the Fountain House model*. Retrieved from ProQuest Dissertations & Theses database. (8619897 Ph.D.)
- Flannery, F., Adams, D., & O'Connor, N. (2011). A community mental health service delivery model: Integrating the evidence base within existing clinical models. *Australasian Psychiatry: Bulletin of Royal Australian And New Zealand College of Psychiatrists*, 19(1), 49-55. doi: 10.3109/10398562.2010.539220

- Furler, J., & Kokanovic, R. (2010). Mental health: Cultural competence. *Australian Family Physician*, 39(4), 206-208.
- Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2004). Ethnic match and treatment outcomes for child and adolescent mental health center clients. *Journal of Counseling and Development*, 82(4), 457-465. doi: 10.1002/j.1556-6678.2004.tb00334.x
- Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and ethnic differences in utilization of mental health services among high-risk youths. *The American Journal of Psychiatry*, 162(7), 1336-1343.
- Germain, C. B. (1978). General-systems theory and ego psychology: An ecological perspective. *Social Service Review*, 52(4), 535-550. doi: 10.2307/30015668
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women. *Mental Health, Religion & Culture*, 10(2), 127-141. doi: 10.1080/13694670500415124
- Goldman, H. H. (2005). Taking issue: The faith community and mental health care. *Psychiatric Services*, 56(2), 133.
- Hall, S. (2010). *With stethoscope in Asia: Korea*. McLean, VA: MCL Associates.
- Hammett, V. B. O., Bodarky, C. J., & Fink, P. J. (1971). An integrated department of psychiatry/community mental health program: One model. *American Journal of Psychiatry*, 127(9).
- Hancock, D. R., & Algozzine, B. (2011). *Doing case study research: A practical guide for beginning researchers* (2nd ed.). New York, NY: Teachers College.
- Herrick, C. A., & Brown, H. N. (1998). Underutilization of mental health services by Asian-Americans residing in the United States. *Issues in Mental Health Nursing*, 19(3), 225-240.
- Hudson, C. G. (1990). The performance of state community mental health systems: A path model. *Social Service Review*, 64(1), 94-120. doi: 10.2307/30012069
- Hyun, K. J. (1995). *Culture and the self: Implications for Koreans' mental health*. Retrieved from ProQuest Dissertations & Theses Full Text database. (9610147)
- Jang, Y., Kim, G., Hansen, L., & Chiriboga, D. A. (2007). Attitudes of older Korean Americans toward mental health services. *Journal of the American Geriatrics Society*, 55(4), 616-620. doi: 10.1111/j.1532-5415.2007.01125.x
- Jang, Y., Kim, G., Hansen, L., & Chiriboga, D. A. (2014). The impact of acculturation on depressive symptoms: A comparison of older Korean Americans in two areas. *Asian American Journal of Psychology*, 5(3), 200.

- Kaltman, S., Pauk, J., & Alter, C. L. (2011). Meeting the mental health needs of low-income immigrants in primary care: A community adaptation of an evidence-based model. *American Journal of Orthopsychiatry*, 81(4), 543-551. doi: 10.1111/j.1939-0025.2011.01125.x
- Kazdin, A. E. (2002). Research design in clinical psychology. (4<sup>th</sup> ed.). Boston, MA: Allyn & Bacon.
- Kellam, S. G., & Sheldon, K. S. (1966). The Woodlawn Mental Health Center: A community mental health center model. *Social Service Review*, 40(3), 255-263. doi: 10.2307/30020199
- Kelley, P. (1994). Integrating systemic and postsystemic approaches to social work practice with refugee families. *Families in Society*, 75(9), 541.
- Khawaja, N. G., McCarthy, R., Braddock, V., & Dunne, M. (2013). Characteristics of culturally and linguistically diverse mental health clients. *Advances in Mental Health*, 11, 169-184.
- Kihlström, A. (2012). Luhmann's system theory in social work: Criticism and reflections. *Journal of Social Work*, 12(3), 287-299. doi: 10.1177/1468017310386425
- Kim, J. (2014). *Grace Community Center status report for annual fund raising dinner* [PowerPoint slides]
- Kim, M. (1990). *Korean-American clergymen's views on mental health and treatment*. Retrieved from ProQuest Dissertations & Theses Full Text database. (9103758)
- Kim, R. (2006). *The perception and expression of psychological health and healing within the Korean American church community: A phenomenological study*. Retrieved from ProQuest Dissertations & Theses database. (UMI No. 3215818)
- Kim, S. C. (1985). Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy: Theory, Research, Practice, Training*, 22(2S), 342-348. doi: 10.1037/h0085513
- Kim, S. S. (2004). The experiences of young Korean immigrants: A grounded theory of negotiating social, cultural, and generational boundaries. *Issues in Mental Health Nursing*, 25(5), 517-537.
- Kim, S. S., & Duckson, G. (2007). Revisiting mental health issues in young immigrants: A lesson learned from the Virginia Tech Massacre. *Mental Health Nursing*, 28(9), 939-942. doi: 10.1080/01612840701522044
- Kim, W. (2002). *Ethnic variations in mental health symptoms and functioning among Asian Americans*. Retrieved from ProQuest Dissertations and Theses database. (3062969)

- Kuo, W. H. (1984). Prevalence of depression among Asian-Americans. *The Journal of Nervous and Mental Disease*, 172(8), 449-457.
- Kwon, H. Y., Kim, K. C., & Warner, R. S. (2001). *Korean Americans and their religions: Pilgrims and missionaries from a different shore*. University Park, PA: Pennsylvania State University Press.
- Lafollette, J., & Pilisuk, M. (1981). Changing models of community mental health services. *Journal of Community Psychology*, 9(3), 210-223.
- Lam, C. S., Tsang, H. W. H., Corrigan, P. W., Lee, Y.-T., Angell, B., Shi, K., . . . Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation*, 76(1), 35-40.
- Laraque, D., & Szilagyi, P. G. (2009). Disparities in utilization of mental health services: Explanations and possible solutions. *Academic Pediatrics*, 9(2), 65-66. doi: 10.1016/j.acap.2009.01.001
- Lee, E.-K. O., & An, C. H. (2013). Faith-based community support for Korean American older adults. *Social Work and Christianity*, 40(4), 446-459. doi: 10.1177/0042098008094873.
- Lee, K. H. (2010). *Help-seeking behaviors by Korean Americans with depression or anxiety*. Retrieved from ProQuest Dissertations and Theses database. (3431369)
- Lee, K. H. (2011). *Stress, religion and mental health outcomes among Asian Americans*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3477939 Ph.D.)
- Lee, S., Juon, H.-S., Martinez, G., Hsu, C., Robinson, E. S., Bawa, J., & Ma, G. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of Community Health*, 34(2), 144-152. doi: 10.1007/s10900-008-9137-1
- Lee, S., Ma, G., Juon, H.-S., Martinez, G., Hsu, C., & Bawa, J. (2011). Assessing the needs and guiding the future: Findings from the health needs assessment in 13 Asian American communities of Maryland in the United States. *Journal of Immigrant and Minority Health*, 13(2), 395-401. doi: 10.1007/s10903-009-9310-3
- Lee, S. G. (2009). *A church growth model in Korean-American Presbyterian churches: With special reference to the Messiah Presbyterian church of Washington*. Retrieved from ProQuest Dissertations & Theses database. (3369640)
- Leech, N., & Onwuegbuzie, A. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly*, 22(4), 557-584. doi: <http://dx.doi.org/10.1037/1045-3830.22.4.557>
- Le Meyer, O., Zane, N., Cho, Y. I., & Takeuchi, D. T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology*, 77(5), 1000-1005. doi: 10.1037/a0017065

- Leff, H. S., Dada, M., & Graves, S. C. (1986). An LP planning model for a mental health community support system. *Management Science*, 32(2), 139-155. doi: 10.1287/mnsc.32.2.139
- Lefley, H. P. P. (1975). Approaches to community mental health: The Miami model. *Psychiatric Annals*, 5(8), 26-32.
- Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, 3(4), 201-214. doi: 10.1300/J051v12n01\_02
- Lin, S. (2011). *Premature dropout from therapy at an ethnic-specific community mental health center*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3481432)
- Lo, C., Cheng, T., & Howell, R. (2014). Access to and utilization of health services as pathway to racial disparities in serious mental illness. *Community Mental Health Journal*, 50(3), 251-257. doi: 10.1007/s10597-013-9593-7
- Lyu, J. (2009). *Marginality and coping: A communal contextual narrative approach to pastoral care with Korean American Christians*. Retrieved from ProQuest Dissertations & Theses database. (3366196)
- Marczyk, G. R., DeMatteo, D., & Festinger, D. (2005). *Essentials of research and methodology*. Hoboken, NJ: John Wiley & Sons.
- Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997). National utilization of mental health services by Asian Americans/Pacific Islanders. *Journal of Community Psychology*, 25(2), 141-145.
- McMinn, M. R., Roh, S. H., McMinn, L. G., Dominguez, A. W., Rhee, E. R., Maurina, A. B.,... Chae, P. K. (2001). Mental health needs and resources in Christian communities of South Korea. *Journal of Psychology and Theology*, 29(2), 140-147.
- Michailakis, D., & Schirmer, W. (2014). Social work and social problems: A contribution from systems theory and constructionism. *International Journal of Social Welfare*, 23(4), 431-442. doi: 10.1111/ijsw.12091
- Mier, N., Ory, M. G., Toobert, D. J., Smith, M. L., Osuna, D., McKay, J. R., . . . Rimer, B. K. (2010). A qualitative case study examining intervention tailoring for minorities. *American Journal of Health Behavior*, 34(6), 822-832.
- Miranda, J., Lawson, W., & Escobar, J. (2002). Ethnic minorities. *Mental Health Services Research*, 4(4), 231-237.
- Miu Ha, K. (2011). Achieving cultural competency in mental health training and practice. *The Journal of Mental Health Training, Education, and Practice*, 6(2), 76-84. doi: <http://dx.doi.org/10.1108/17556221111168922>

- Morgan, C., & Hutchinson, G. (2010). The social determinants of psychosis in migrant and ethnic minority populations: A public health tragedy. *Psychological Medicine*, 40(5), 705-709. doi: 10.1017/S0033291709005546
- Moritsugu, J., Vera, E., Wong, F., & Duffy, K. G. (2014). *Community psychology*. New York, NY: Pearson.
- O'Donoghue, T., & Punch, K. (2003). *Qualitative educational research in action: Doing and reflecting*. New York, NY: Routledge Falmer.
- Park, P. J. (2012). *Overcoming the barriers to mental health treatment services in Korean American populations: A phenomenological study*. Retrieved from ProQuest Dissertations & Theses database. (3498451)
- Park, S. Y., & Bernstein, K. S. (2008). Depression and Korean American immigrants. *Archives of Psychiatric Nursing*, 22(1), 12-19. doi: 10.1016/j.apnu.2007.06.011
- Patel, K. K., Frausto, K. A., Staunton, A. D., Souffront, J., & Derosé, K. P. (2013). Exploring community health center and faith-based partnerships: Community residents' perspectives. *Journal of Health Care for the Poor and Underserved*, 24(1), 262-274.
- Phinney, J. S., Horenczyk, G., Liebkind, K., & Vedder, P. (2001). Ethnic identity, immigration, and well-being: An interactional perspective. *Journal of Social Issues*, 57(3), 493-510. doi: 10.1111/0022-4537.00225
- PolicyLink, & PERE. (2015). *Equitable Growth Profile of Fairfax County*. Retrieved from [http://nationalequityatlas.org/sites/default/files/Fairfax\\_Summary\\_16June2015\\_Final.pdf](http://nationalequityatlas.org/sites/default/files/Fairfax_Summary_16June2015_Final.pdf)
- Reed, G. M., & Collins, B. E. (1994). Mental health research and service delivery: A Three Communities Model. *Psychosocial Rehabilitation Journal*, 17(4), 69-81. doi: 10.1037/h0095555
- Rhee, S., Chang, J., & Youn, S. (2003). Korean American pastors' perceptions and attitudes toward child abuse. *Journal of Ethnic and Cultural Diversity in Social Work*, 12(1), 27-46. doi: 10.1300/J051v12n01\_02
- Rosen, A., Gurr, R., Fanning, P., & Owen, A. B. (2012). The future of community-centred health services in Australia: 'When too many beds are not enough'. *Australian Health Review*, 36(3), 239-243. doi: 10.1192/bjp.bp.108.051698
- Royeen, M., & Ramsay, D. (2000). Way Station: A model of excellence in community mental health programs. *Occupational Therapy in Health Care*, 12(4), 65-78.
- Shin, J. K. (2002). Help-seeking behaviors by Korean immigrants for depression. *Issues in Mental Health Nursing*, 23(5), 461-476.



- Sin, M.-K., Jordan, P., & Park, J. (2011). Perceptions of depression in Korean American immigrants. *Issues in Mental Health Nursing*, 32(3), 177-183. doi: 10.3109/01612840.2010.536611
- Smith, T. E., Erlich, M. D., & Sederer, L. I. (2013). Integrating general medical and behavioral health care: The New York state perspective. *Psychiatric Services*, 64(9), 828-831.
- Stacciarini, J. M., Shattell, M. M., Coady, M., & Wiens, B. (2011). Review: Community-based participatory research approach to address mental health in minority populations. *Community Mental Health Journal*, 47(5), 489-497. doi: 10.1007/s10597-010-9319-z
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: SAGE.
- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59(4), 533-540. doi: 10.1037/0022-006X.59.4.533
- Takeuchi, D. T., Mokuau, N., & Chun, C.-A. (1992). Mental health services for Asian Americans and Pacific Islanders. *Journal of Mental Health Administration*, 19(3), 237-245.
- Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology*, 41(3), 280-287. doi: 10.1037/0022-0167.41.3.280
- Taylor-Powell, E., & Henert, E. (2008). *Developing a logic model: Teaching and training guide* [PDF document]. Retrieved from <http://www.uwex.edu/ces/pdande/evaluation/pdf/lmguidcomplete.pdf>
- U.S. Census Bureau. (2012, March). *The Asian Population: 2010*. Retrieved from <https://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf>
- U.S. Department of Health & Human Services (2015). *HHS awards more than \$240 million to expand the primary care workforce*. Retrieved from <http://www.hhs.gov/about/news/2015/10/14/hhs-awards-more-240-million-expand-primary-care-workforce.html#>
- U.S. Department of Health & Human Services Office of Minority Health (2010). *Advancing health equity at every point of contact*. Retrieved from <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>
- White House Initiative on Asian Americans and Pacific Islanders. (2010). *The AAPI community: Demographics* [PDF file]. Retrieved from [http://www.whitehouse.gov/sites/default/files/docs/infographic\\_1.pdf](http://www.whitehouse.gov/sites/default/files/docs/infographic_1.pdf)

- Wisconsin-Extension, U. O. (2003). *Enhancing Program Performance with Logic Models* [PDF document]. Retrieved from <http://www.uwex.edu/ces/pdande/evaluation/pdf/lmcourseall.pdf>
- Wong, C. C. (2006). *Examining barriers and facilitators to professional mental health help-seeking in Asian American youth*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3231073)
- Wu, M. C., Kviz, F. J., & Miller, A. M. (2009). Identifying individual and contextual barriers to seeking mental health services among Korean American immigrant women. *Issues in Mental Health Nursing*, 30(2), 78-85. doi: 10.1080/01612840802595204
- Xu, H. U. A., & Morgan, K. (2012). Public-private partnerships for social and human services: A case study of nonprofit organizations in Alabama. *Public Administration Quarterly*, 36(3), 277-310.
- Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S.,... Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *The Journal of Behavioral Health Services & Research*, 29(1), 45-60.
- Yeung, A., Kung, W. W., Chung, H., Rubenstein, G., Roffi, P., Mischoulon, D., & Fava, M. (2004). Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *General Hospital Psychiatry*, 26(4), 256-260. doi: 10.1016/j.genhosppsych.2004.03.008
- Yi, G.-H. H. (2007). *Ethnic support, religious support, gratitude, and psychological functioning in Korean American Christians*. Retrieved from ProQuest Dissertations & Theses Full Text database. (3262582)
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: SAGE.
- Zane, N., Hatanaka, H., Park, S. S., & Akutsu, P. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian-American clients. *Journal of Community Psychology*, 22(2), 68-81.
- Zhang, A. Y., & Snowden, L. R. (1999). Ethnic characteristics of mental disorders in five U.S. communities. *Cultural Diversity and Ethnic Minority Psychology*, 5(2), 134-146. doi: 10.1037/1099-9809.5.2.134
- Ziguras, S., Klimidis, S., Lewis, J., & Stuart, G. (2003). Ethnic matching of clients and clinicians and use of mental health services by ethnic minority clients. *Psychiatric Services*, 54(4). doi: 10.1176/appi.ps.54.4.535

## **APPENDIX A: The National CLAS Standard**

The national standard for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

### **Principal Standard**

**1)** Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### **Governance, Leadership and Workforce**

**2)** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

**3)** Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

**4)** Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.  
Communication and Language Assistance

**5)** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

**6)** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

**7)** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

**8)** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

### **Engagement, Continuous Improvement and Accountability**

**9)** Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

**10)** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

- 11)** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- 12)** Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- 13)** Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
- 14)** Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
- 15)** Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

The above content is taken on March 5<sup>th</sup> 2016 from  
<http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>

## APPENDIX B

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Interview Assent for Youth Council

Date

Name

Address

Dear WCCI Youth Council member:

I am doing a research study about how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. As part of my study, I would like to interview you (one time for 90-120 minutes in person) about your experience as a youth council member. The interview will be audio recorded and transcribed, which you will be able to review for its accuracy.

When I am finished with this study, I will write a report about what has been learned. This report will not include your name or that you were in the study. There may not be a direct personal benefit for you to participate in this study. However, what is learned from this study may benefit other youth students like yourself in the Korean American community and other ethnic immigrant communities with similar needs.

Taking part in this study is completely voluntary. You do not have to be in this study if you do not want to be. If you decide to stop after we begin, that's okay too. It will not affect your status in WCCI Youth Council in any way. Your parents have been informed about the study as well.

Thank you for considering my request. If you choose to participate, please sign your name.

I, \_\_\_\_\_, want to be in this research study.

\_\_\_\_\_  
(Sign your name here)

\_\_\_\_\_  
(Date)

Sincerely,

Gemma I. Sohn

## APPENDIX C

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Assent for Youth Council

Date  
Name  
Address

Dear WCCI Youth Council member:

I am doing a research study about how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. As part of my study, I would like to observe and record one of your ongoing Youth Council sessions you participate in regularly. If you decide that you want to be a part of this study by participating in a session, I will be observing you along with the rest of the students in the group.

I am writing to request your agreement for participation in this study. When I am finished with this study, I will write a report about what has been learned. This report will not include your name or that you were in the study. There may not be a direct personal benefit for you to participate in this study. However, what is learned from this study may benefit other youth students like yourself in the Korean American community and other ethnic immigrant communities with similar needs.

Taking part in this study is completely voluntary. You do not have to be in this study if you do not want to be. If you decide to stop after we begin, that's okay too. It will not affect your status in WCCI Youth Council in any way. Your parents have been informed about the study as well.

Thank you for considering my request. If you choose to participate, please sign your name.

I, \_\_\_\_\_, want to be in this research study.

\_\_\_\_\_  
(Sign your name here)

\_\_\_\_\_  
(Date)

Sincerely,

Gemma I. Sohn

## APPENDIX D

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Consent Form for Interview (Parent/Guardian of Interviewee)

#### A CASE STUDY OF AN ETHNICALLY TAILORED, COMMUNITY-CENTERED, FAITH- BASED, NONPROFIT, MENTAL HEALTH PROGRAM: THE SERVICE DELIVERY MODEL OF COLLABORATION AND INTEGRATION AT WASHINGTON CHRISTIAN COUNSELING INSTITUTE

Gemma I. Sohn  
Liberty University

I, Gemma I. Sohn, a doctoral candidate in the counseling department at Liberty University am conducting a study in fulfillment of the degree requirements for Doctor of Philosophy. Your child is invited to participate in this study of understanding how Washington Christian Counseling Institute (WCCI) programs are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. Your child was selected as a possible participant because he/she was/is a service provider/recipient of WCCI programs. I ask that you read carefully the following information and ask any questions you may have before agreeing to allow your child to participate in the study.

#### **Background Information:**

The purpose of this study is to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. By describing and investigating WCCI's programs, a larger purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans will be sought.

#### **Procedures:**

If you agree, your child will be asked

- 1) to participate in a 90-120 minute interview, and
- 2) to allow his/her interview to be audio-recorded and to review the transcript for its accuracy.

#### **Risks and Benefits of being in the Study:**

The risk involved in this study is minimal and the risks are no more than your child would encounter in everyday life. The researcher may become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse, or intent to harm self or others. In this type of research, it must be disclosed as a risk to him/her or others. Should your child experience any psychological distress during his/her participation, your child may terminate the process at any time. If and when your child is psychologically distressed during the research period, he/she will be provided a referral to a professional mental health clinician.



## APPENDIX E

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Consent Form for Observation (Parent/Guardian of Interviewee)

#### A CASE STUDY OF AN ETHNICALLY TAILORED, COMMUNITY-CENTERED, FAITH- BASED, NONPROFIT, MENTAL HEALTH PROGRAM: THE SERVICE DELIVERY MODEL OF COLLABORATION AND INTEGRATION AT WASHINGTON CHRISTIAN COUNSELING INSTITUTE

Gemma I. Sohn  
Liberty University

I, Gemma I. Sohn, a doctoral candidate in the counseling department at Liberty University am conducting a study in fulfillment of the degree requirements for Doctor of Philosophy. Your child is invited to participate in this study of understanding how Washington Christian Counseling Institute (WCCI) programs are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. Your child was selected as a possible participant because your child was/is a service recipient of WCCI programs. I ask that you read carefully the following information and ask any questions you may have before agreeing to allow your child to participate in the study.

#### **Background Information:**

The purpose of this study is to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. By describing and investigating WCCI's programs, a larger purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans will be sought.

#### **Procedures:**

If you agree, your child will be asked

- 1) to allow an observation of his/her participation in a 90-120 minute focus group he/she is a part of, and
- 2) to allow his/her participation to be audio-recorded

#### **Risks and Benefits of being in the Study:**

The risk involved in this study is minimal and the risks are no more than your child would encounter in everyday life. The researcher may become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse, or intent to harm self or others. In this type of research, it must be disclosed as a risk to him/her or others. Should your child experience any psychological distress during his/her participation, your child may terminate the process at any time. If and when your child is psychologically distressed during the research period, he/she will be provided a referral to a professional mental health clinician.



## APPENDIX F

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Consent Form for Interview

#### A CASE STUDY OF AN ETHNICALLY TAILORED, COMMUNITY-CENTERED, FAITH- BASED, NONPROFIT, MENTAL HEALTH PROGRAM: THE SERVICE DELIVERY MODEL OF COLLABORATION AND INTEGRATION AT WASHINGTON CHRISTIAN COUNSELING INSTITUTE

Gemma I. Sohn  
Liberty University

I, Gemma I. Sohn, a doctoral candidate in the counseling department at Liberty University am conducting a study in fulfillment of the degree requirements for Doctor of Philosophy. You are invited to participate in this study of understanding how Washington Christian Counseling Institute (WCCI) programs are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. You were selected as a possible participant because you were/are a service provider/recipient of WCCI programs. I ask that you read carefully the following information and ask any questions you may have before agreeing to participate in the study.

#### Background Information:

The purpose of this study is to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. By describing and investigating WCCI's programs, a larger purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans will be sought.

#### Procedures:

If you agree to be in this study, you will be asked

- 1) to be available for a one-time, 90-minute, face-to-face interview,  
and
- 2) to allow your participation to be audio-recorded and to review the transcript for accuracy.

#### Risks and Benefits of being in the Study:

The risk involved in this study is minimal and the risks are no more than you would encounter in everyday life. The researcher may become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse, or intent to harm self or others. In this type of research, it must be disclosed as a risk to yourself or others. Should you experience any psychological distress during your participation, you may terminate the process at any time. If and when you are psychologically distressed during the research period, you will be provided a referral to a professional mental health clinician.

## APPENDIX G

The Liberty University Institutional  
Review Board has approved  
this document for use from  
8/31/15 to 8/30/16  
Protocol # 2270.083115

### Consent Form for Observation

#### A CASE STUDY OF AN ETHNICALLY TAILORED, COMMUNITY-CENTERED, FAITH- BASED, NONPROFIT, MENTAL HEALTH PROGRAM: THE SERVICE DELIVERY MODEL OF COLLABORATION AND INTEGRATION AT WASHINGTON CHRISTIAN COUNSELING INSTITUTE

Gemma I. Sohn  
Liberty University

I, Gemma I. Sohn, a doctoral candidate in the counseling department at Liberty University am conducting a study in fulfillment of the degree requirements for Doctor of Philosophy. You are invited to participate in this study of understanding how Washington Christian Counseling Institute (WCCI) programs are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. You were selected as a possible participant because you were/are a service recipient of WCCI programs. I ask that you read carefully the following information and ask any questions you may have before agreeing to participate in the study.

#### **Background Information:**

The purpose of this study is to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. By describing and investigating WCCI's programs, a larger purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans will be sought.

#### **Procedures:**

If you agree to be in this study, you will be asked

- 1) to allow an observation of your participation in a 90-120 minute focus group you are part of, and
- 2) to allow your participation to be audio-recorded and to review the transcript for accuracy.

#### **Risks and Benefits of being in the Study:**

The risk involved in this study is minimal and the risks are no more than you would encounter in everyday life. The researcher may become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse, or intent to harm self or others. In this type of research, it must be disclosed as a risk to yourself or others. Should you experience any psychological distress during your participation, you may terminate the process at any time. If and when you are psychologically distressed during the research period, you will be provided a referral to a professional mental health clinician.

## APPENDIX H

### Research Permission Letter

July 29, 2015

Tong S. Park, M.D.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dear Dr. Park:

As a graduate student in the counseling department at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The title of my research project is A Case Study of an Ethnically Tailored, Community-Centered, Faith-Based, Nonprofit , Mental Health Program : Service Delivery Model of Collaboration and Integration at Washington Christian Counseling Institute, and the purpose of my research is to understand how the programs offered by the Washington Christian Counseling Institute (WCCI) are meeting the mental health needs of the Korean American immigrant community in the Washington D.C. metropolitan area. By describing and investigating WCCI's programs, the larger purpose of providing a viable mental health service delivery model for immigrant minority communities such as Korean Americans will be met.

I am writing to request your permission to conduct my research at the current location of Grace Community Center and to utilize your staff (service providers) and clients (service recipients) as participants for my research , as well as to have access to available records.

Participants will be contacted individually with my invitation to participate in the study. Also, the participants will be presented with a description of the study, and his/her informed consent will be obtained prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission , please respond by email to

[REDACTED]

Sincerely

Gemma I. Sohn

**APPENDIX I****Research Permission Letter**

July 31, 2015

Gemma I. Sohn

[REDACTED]

[REDACTED]

Dear Gemma:

It is our pleasure to grant our permission for the research proposal of "A Case Study of an Ethnically Tailored, Community-Centered, Faith-Based, Nonprofit, Mental Health Program: Service Delivery Model of Collaboration and Integration at Washington Christian Counseling Institute" to be conducted at our WCCI.

We think your research will provide us not only the data of what has been done here but also provide us with a valuable insight of what can be improved to meet the needs of the under-served population with various ethnic backgrounds of our community.

Regards,

Tong S. Park, M.D.

Vice Chairman of Board of Directors

Grace Community Center

[REDACTED]

[REDACTED]

## APPENDIX J

# LIBERTY UNIVERSITY

## INSTITUTIONAL REVIEW BOARD

August 31, 2015

Gemma Imsook Sohn

IRB Approval 2270.083115: A Case Study of an Ethnically Tailored, Community-Centered, Faith-Based, Nonprofit, Mental Health Program: The Service Delivery Model of Collaboration and Integration at Washington Christian Counseling Institute

Dear Gemma,

We are pleased to inform you that your study has been approved by the Liberty IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year, or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases were attached to your approval email.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

**G. Michele Baker, MA, CIP**  
*Administrative Chair of Institutional Research*  
**The Graduate School**

**LIBERTY**  
UNIVERSITY.  
*Liberty University | Training Champions for Christ since 1971*

## APPENDIX K

### JOHN WILEY AND SONS LICENSE TERMS AND CONDITIONS

Aug 04, 2016

---

This Agreement between Gemma I Sohn ("You") and John Wiley and Sons ("John Wiley and Sons") consists of your license details and the terms and conditions provided by John Wiley and Sons and Copyright Clearance Center.

License Number	3917650366280
License date	Jul 28, 2016
Licensed Content Publisher	John Wiley and Sons
Licensed Content Publication	Acta Psychiatrica Scandinavica
Licensed Content Title	Migration and mental health
Licensed Content Author	D. Bhugra
Licensed Content Date	Mar 3, 2004
Licensed Content Pages	16
Type of use	Dissertation/Thesis
Requestor type	University/Academic
Format	Print and electronic
Portion	Figure/table
Number of figures/tables	1
Original Wiley figure/table number(s)	figure 2
Will you be translating?	No
Title of your thesis / dissertation	A CASE STUDY OF AN ETHNICALLY-TAILORED COMMUNITY-BASED MENTAL HEALTH PROGRAM: WASHINGTON CHRISTIAN COUNSELING INSTITUTE
Expected completion date	Aug 2016
Expected size (number of pages)	200