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THE EFFECTS OF USING EXPRESSIVE INTERVENTION IN GROUP COUNSELING ON  
ACCULTURATIVE STRESS AND DEPRESSIVE SYMPTOMS AMONG KOREAN  
IMMIGRANT WOMEN IN SOUTH AND CENTRAL TEXAS:  
AN EXPERIMENTAL STUDY

A  
DISSERTATION

Presented to the Faculty of the Graduate School of  
St. Mary's University in Partial Fulfillment  
of the Requirement  
for the Degree of

DOCTOR OF PHILOSOPHY

In  
COUNSELOR EDUCATION AND SUPERVISION

by  
Sun-kyung Chung, M.A.

San Antonio, Texas

2018

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ACCULTURATIVE STRESS AND DEPRESSIVE SYMPTOMS AMONG KOREAN  
IMMIGRANT WOMEN IN SOUTH AND CENTRAL TEXAS:  
AN EXPERIMENTAL STUDY

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## ABSTRACT

THE EFFECTS OF USING EXPRESSIVE INTERVENTION IN GROUP COUNSELING ON  
ACCULTURATIVE STRESS AND DEPRESSIVE SYMPTOMS AMONG KOREAN  
IMMIGRANT WOMEN IN SOUTH AND CENTRAL TEXAS:  
AN EXPERIMENTAL STUDY

Sun-kyung Chung, MA, LPC

St. Mary's University, December 2018

Dissertation Adviser: Melanie Harper, Ph. D.

This study evaluated the relationship between acculturative stress and depressive symptoms in Korean immigrant women and evaluated the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. Participants were randomly assigned to the intervention or control group. The intervention group received a total of four sessions of expressive group counseling interventions while the control group was asked to color pictures at home. Pearson correlations found statically significant relationships between acculturative stress and depressive symptoms in Korean immigrant women. The results of a one-way analysis of covariance (ANCOVA) indicated no statistically significant difference in the effect of expressive group counseling on the acculturative stress between the intervention and control groups. However, ANCOVA indicated a statistically significant difference in the effect of expressive group counseling on the depressive symptoms between the intervention and control groups.

## CHAPTER I:

### THE PROBLEM AND JUSTIFICATION OF THE STUDY

The demographics of the United States show a wide variety of ethnicities. The United States is known as a country that is ethnically and culturally diverse (Yoo & Vonk, 2012). The current population of foreign-born residents in the U.S. is calculated at 40 million, and it occupies 13% of the total population in the U.S. (Passel & Cohn, 2012; U.S. Census Bureau, 2012c). Individuals from foreign nations have continually immigrated to the U.S. Waves of immigration in the U.S. began during the colonial era (Britt-Mills, 2010). Although the early immigrants generally moved to the U.S. to seek better economic opportunities, to find religious freedom, and to obtain political freedom (Ewing, 2012), current immigrants come to the U.S. for academic or vocational education, to represent foreign governments and international organizations, and for greater economic opportunities. Initially, immigrants to the U.S. arrived from European countries (Ewing, 2012; U.S. Census Bureau, 2013). After 1960, the waves of immigration rapidly rose from Latin America and Asia (Ewing, 2012; U.S. Census Bureau, 2012c; U.S. Census Bureau, 2013). The U.S. Census Bureau (2012a) estimates that the current largest groups of immigrants in the U.S. are from Latin America (53%) and Asia (28%), followed by Europe (12%), Africa (4%), Northern America (2%), and Oceania (less than 1%).

Typically, the United States encouraged diversity in its inhabitants, as evidenced by its continued modification of immigration policies (Center for Immigration Studies, Historical Overview of Immigration Policy, 2010). Since its inception, the U.S. has strengthened policies that support the coexistence of various conventions, cultures, and customs. Consequently, the U.S. has an invested interest in improving the experiences of immigrants and subsequently creating social supports for immigrants, including education, healthcare, and mental health services. Many researchers have conducted studies on the experiences that foreign-born

populations have faced when entering the new culture in the United States. Most researchers, however, have focused on the psychological effect of immigration on the individual and often limited their focus to European immigrant experiences.

Asian Americans and immigrants have increased faster in the United States than in any country (Kim, Yang, Atkinson, Wolfe, & Hong, 2001; Liu, Pope-Davis, Nevitt, & Toporek, 1999; U.S. Census Bureau, 2012a, 2013; Vega & Rumbaut, 1991). Asians are people who have their origins in the Far East, Southeast Asia, or the Indian subcontinent (Jeong & You, 2008). According to the U.S. Census Bureau (2012c), the number of foreign-born residents from Asia has rapidly grown in the United States, “from about 0.5 million in 1960 to 11.6 million in 2011” (p.1). Due to growth of the Asian population in the U.S., many mental health providers have become interested in Asians’ experiences in the U.S. (Chu & Sue, 2011; Kuo, 1984; Li, 2016; Nandan, 2005; Noh & Avison, 1996; Noh & Kaspar, 2003; Park, Anastas, Shibusawa, & Nguyen, 2014; Rhee, 2009; Tummala-Narra, Alegria, & Chen, 2012). Despite an increasing Asian American population, there still is not sufficient understanding of Asian Americans’ common psychological issues and culturally appropriate counseling approaches.

The mental health profession has given limited attention to the acculturation experiences of Asian immigrants. Previous research of Asian immigrants has been aimed mainly at the young Asian population (children, adolescents, or college youths), but younger immigrants have higher linguistic ability with English and greater ability to adapt to a new culture than adults (Chung, 2001; Kim, 2007; Lee, Su, & Yoshida, 2005; Leong, Kao, & Lee, 2004). Furthermore, many studies of Asian immigrants were primarily focused on certain limited topics, including Asian values, generational conflicts with parents, career development, help-seeking attitudes, and educational and occupational success of Asian children (Chung, 2001; Kim, 2007; Lee et al., 2005; Leong et al., 2004). The purpose of this study is to evaluate the relationship between

acculturative stress and depressive symptoms in Korean immigrant women and to evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms.

### **Statement of the Problem**

Stress is a pattern of unwanted physiological complaints and psychological reactions that appear in people who experience threats to their well-being and cannot maintain their well-being (Lazarus & Folkman, 1984). Life continually creates stress, and people may automatically think that stress is something negative in daily life. Stress involves a stressor (Wethington, 2016), and the stressor naturally occurs when individuals encounter any demand or event that "overwhelms [them] or disturbs [their] equilibrium" (Cook, Thompson, & Coca-Lyle, 2011, p.124). When stress becomes overwhelming or not appropriately negotiated, it can damage a person's health, emotions, mood, relationships, achievements, abilities, and quality of life. Additionally, stress is considered an influencer in the pathogenesis of physical diseases by causing negative affective states that directly affect biological processes or behavioral patterns, which increase the risk of disease in general (Cohen, Kessler, & Gordon, 1997). Therefore, it is essential for people to understand how they physically and mentally respond to stress and to develop appropriate coping skills for obtaining healthy and positive outcomes following stress.

Immigration is a stressful experience for people of any age (Ayers et al., 2009; Benish-Weisman, 2009; Berry, 1997, 2001, 2005; Park & Rubin, 2012; Park & Bernstein, 2008; Park, Cho, Park, Bernstein, & Shin, 2013; Sabatier & Berry, 2008; Shin, Han, & Kim, 2007; Sin, Jordan, & Park, 2011). Moving to a new country can be a stressful and challenging process, regardless of whether the person immigrated voluntarily or involuntarily. Immigrants not only physically leave their place of origin, but also leave their place of socialization and their



traditional values of origin (Lin, Ye, & Ensel, 1999; Nah, 1993; Shen & Takeuchi, 2001; Sonderegger & Barrett, 2004).

Berry (1997) stated that immigrants face various physical, psychological, social, and cultural changes while adapting to a new culture. Additionally, recently arrived immigrants encounter a number of stressors and risks such as a different climate, language barriers (Nandan, 2005; Yakhnich, 2008), missing family members (Bernier, 1992; Eisenbruch, 1991), unfamiliar customs, ethnic identification, different culture, new norms, insecure jobs (Edelstein, 2005; Yakhnich, 2008), poverty, discrimination (Liebkind, & Jasinskaja-Lahti, 2000), and social isolation (Finch, Catalano, Novaco, & Vega, 2003; Hiott, Grzywacz, Davis, Quandt, & Arcury, 2008; Kiang, Grzywacz, Marin, Arcury, & Quandt, 2010).

Acculturation is a process of modification for people who came from another culture, and their behaviors and attitudes are socialized into those of the majority cultural group during this process (Rogler, Cortes, & Malgady, 1991). Acculturation is a stressful period and an essential factor for immigrants' adjustment (Ayers et al., 2009; Berry, 2005; Berry & Kim, 1988; Choi, Miller, & Wilbur, 2009; Hwang & Ting, 2008; Kim et al., 2001; Lee, Moon, & Knight, 2004; Park & Bernstein, 2008; Rogler et al, 1991; Rudmin, 2009; Shen & Takeuchi, 2001; Torres, 2010). Acculturative stress is what immigrants may experience during the process of acculturation, while they attempt to solve their problems and conflicts of adjustment and integrate into a new culture (Berry & Kim, 1988). Studies have shown that acculturative stress is associated with depression (Rhee, 2009; Tummala-Narra, Alegria, & Chen, 2012) or depressive symptoms (Oh, Koeske, & Sales, 2002; Rhee, 2016) among various groups of immigrants in the U.S.

Depression is distinct from usual mood fluctuations, such as normal emotional responses to loss or life challenges. Depression negatively impacts an individual's feelings, thoughts, and

behaviors (American Psychiatric Association, 2013; Gellman & Turner, 2013a, 2013b; U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 2015; World Health Organization, 2017). According to the American Psychiatric Association (2013), depressive symptoms include not only depressed mood, but also the loss of interest or pleasure in nearly all activities. Individuals who experience depressive symptoms often describe their feeling as depressed, sad, hopeless, discouraged, or down in the dumps. Additionally, the depressive symptom can impair functioning if it is not addressed or dealt with. Some studies found a higher risk of depression among Asian immigrants than among the non-Hispanic white population (Gavin et al., 2010; Kim, Park, Storr, Tran, & Juon, 2015; Min, Moon, & Lubben, 2005; Stokes, Thompson, Murphy, & Gallagher-Thompson, 2002; Yeung et al., 2004).

According to the U.S. Census Bureau (2012b, 2012c), Korea is the fifth largest ethnic Asian group in the United States account for 9% of the foreign-born Asian residents (2012b). Studies have shown that Korean immigrants reported high levels of psychological stress, which related to struggles in values, beliefs, and behaviors between the host society and their own ethnic group (Chun, Knight, & Youn, 2007; Kim, Han, Shin, Kim, & Lee, 2005; Park et al., 2013; Shin, 1993). Additionally, studies have reported psychological issues commonly associated with depression in Korean immigrants (Ayers et al., 2009; Bernstein, Park, Shin, Cho, & Park, 2011; Jang, Kim, & Chiriboga, 2011; Min et al., 2005; Shin, 1993). According to previous studies, Korean immigrants reported higher level of depressive symptoms than other Asian and non-Asian immigrant subgroups (Ayers et al., 2009; Bernstein et al., 2011; Gavrilovic, 2012; Hurh & Kim, 1990; Kim et al., 2015; Jang et al., 2011; Kuo, 1984; Min et al., 2005; Shin, 1993).

However, Korean immigrants are less likely to access treatment of depression or to receive adequate mental health care because of a lack of language proficiency, insurance, culture and perception of chronic health issues, especially mental health (Cheung, Leung, & Cheung, 2011; Park et al., 2013; Shin, 2002). Additionally, many Korean immigrants are not aware of professional mental health resources. Disclosing mental issues among Korean immigrants is nearly always held in secrecy and often denial and considered shameful. Korean immigrants have tended to seek help with their mental health problems from physicians and non-mental health professionals including friends, families, and religious healers (Cheung et al., 2011). According to Park et al. (2013), Korean immigrants with depressive symptoms may not look for help in the mental health system because they were not aware of the benefit from mental health services. Because of the cultural norm that mental health services may help them, and due to the lack of their help-seeking behaviors regarding mental health, Korean immigrants' stress management and coping mechanisms remain unclear, even though they have been reported to experience higher psychological issues.

Although education programs are needed for Korean immigrants to learn the cause of their mental health issues and the benefits to receive appropriate treatment, there are few educational programs available to them. Additionally, mental health professionals have little direction regarding how to effectively help Korean immigrants, and culturally competent approaches are greatly needed when working with Korean immigrants. Lack of culturally sensitive and language appropriate materials from mental health professionals, mental health treatment for Koreans may not provide effective and adequate help. Researching additional culturally adapted treatments for this population is needed in order to develop treatments that are known to be effective with this population. The researcher utilized many databases to explore expressive group counseling interventions among Korean immigrant women including Academic

Search Complete, PsychARTICLES, PsychINFO, and Psychology and Behavioral Sciences. To date, no research has been done on expressive group counseling interventions among Korean immigrant women.

### **Research Questions**

The research methodology for this study was a pilot experimental treatment design. First, the relationship between acculturative stress and depressive symptoms among Korean women who have immigrated to the United States was evaluated because although this relationship has been shown for Asians in general, it is not clear that it exists for Korean women. The experimental treatment consisted of expressive group counseling interventions for the Korean women who immigrated to the U.S. Both the treatment group and a control group had their acculturative stress and depressive symptoms measured at the onset of the study and three weeks later (one week after the treatment group completed the expressive group counseling interventions). Participants were randomly assigned to the control and interventions groups. Data was collected and measured by the researcher to evaluate a change between pre- and post-tests. Self-report instruments were used to collect demographic information and to measure acculturative stress and depressive symptoms.

The participants were adult Korean immigrant women who: 1) were born in Korea; 2) currently live in the southern or central regions of Texas; 3) are at least 18 years old; 4) immigrated to the U.S. from Korea after their 16th birthday; 5) have lived in the United States more than six months; 6) are able to speak, read, and write Korean; 7) currently do not receive any therapeutic treatments, 8) have self-identified that they have experienced acculturative stress and depressive symptoms; and 9) voluntarily want to participate in this research.

This study addresses the following research questions:

- (1) Is acculturative stress positively related to depressive symptoms in Korean women who have immigrated to the United States and live in the southern or central region of Texas?
- (2) Does acculturative stress significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for depressive symptoms?
- (3) Do depressive symptoms significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for acculturative stress?

### **Justification of Study**

Depression and depressive symptoms are highly prevalent among Korean immigrant women in the U.S. (Ayers et al., 2009; Bernstein et al., 2011; Gavrilovic, 2012; Hurh & Kim, 1990; Kim et al., 2015; Jang et al., 2011; Kuo, 1984; Min et al., 2005; Shin, 1993) and more research is needed to help mental health professionals in offering more effective treatment of depressive symptoms (Ayers et al., 2009; Bernstein et al., 2011; Gavrilovic, 2012; Hurh & Kim, 1990; Kim et al., 2015; Jang et al., 2011; Kuo, 1984; Min et al., 2005; Shin, 1993). Korean immigrants do not acknowledge the importance of mental health care or psychological

counseling and rarely present early for treatment of acculturative stress and depressive symptoms (Cheung et al., 2011; Park et al., 2013; Shin, 2002). Limited research has been conducted to develop effective education programs to inform Korean immigrants of the importance of mental health care and to evaluate treatments for this population (Ayers et al., 2009; Bernstein et al., 2011; Cheung et al., 2011; Gavrilovic, 2012; Hurh & Kim, 1990; Kim et al., 2015; Jang et al., 2011; Kuo, 1984; Min et al., 2005; Park et al., 2013; Shin, 1993).

Bae (2013) conducted research to develop an international web-based expert system using principles of artificial intelligence and user-centered design for the management of mental health by Korean immigrants. A survey was done with 3,235 Korean immigrants from all over the world and focus group interviews were conducted. Findings suggested that this system is interactive and accessible to anyone in the world and provides accurate information to assist Korean immigrant for preventive education. However, the study did not report how this system effectively promotes mental health care among Korean immigrants.

Jang et al. (2013) conducted research that examined the use of telehealth technology in providing access to culturally and linguistically appropriate mental health services among elderly Korean immigrants. Fourteen elderly Korean immigrants who lived in a low-income housing facility in Orlando, Florida participated in four weekly sessions that were conducted by four Korean mental health counselors in New York. Depressive symptoms were assessed with the Patient Health Questionnaire (PHQ-9) during the first counseling session and within three days after the completion of the four-week counseling program. Findings indicated that depressive symptoms of participants were significantly changed ( $t = 13.1, p < .001$ ) from pre-assessment ( $M = 11.6, SD = 2.14$ ) to post-assessment ( $M = 8.50, SD = 2.27$ ). Additionally, PHQ-9 scores averaged 9.25 ( $SD = 2.00$ ) at the three-month follow-up, which was significantly higher than the mean at the post-assessment ( $t = -2.46, p < .05$ ), but still lower than that at the preassessment ( $t =$

10.5,  $p < .001$ ). The findings suggested that the depressive symptoms were reduced on completion of the program; however, the experimental benefit did not maintain at a statistically significant level after three months.

Cho, Bernstein, Roh, and Chen (2013) conducted research that investigated the impact of logo-autobiography (LA) as a therapeutic modality for Korean immigrant women who suffered from depression and perceived their lives as meaningless. The study was nonrandomized quasi-experimental research with a pre-test, a post-test, and a follow-up test. The pre-test was conducted before the first session of the LA, the post-test was given immediately after the last session of the LA, and the follow-up test was done after four-weeks. Forty participants were assigned to either the experimental group or the control group based on their preferences. Findings indicated that the experimental group reported a significantly lower score on depressive symptoms ( $F = 6.832, p = .013$ ;  $F = 19.800, p \leq .001$ ) and a higher score on meaning of life ( $F = 12.294, p = .001$ ;  $F = 12.232, p = .001$ ) than did the control group immediately after completing the LA and a 4-week follow-up. Additionally, the LA as a therapeutic modality is effectively reduced depressive symptoms and increased a sense of meaning in life among Korean immigrant women suffering from depression.

Greater effort needs to be made for exploration and establishment of mental health education that will increase access to help Korean immigrant women seeking mental health care, including, adequate treatments and referral systems, which would be more beneficial than the current forms of help-seeking. Additionally, studies need to provide information to develop culturally appropriate interventions for Korean immigrant women to suggest successful coping strategies to prevent or reduce depression among Korean immigrant women.

### **Limitations**

The present study had several limitations. The first limitation of this research study was that the participants were recruited based on their accessibility and willingness to participate in this research. The participants in the study may not provide an accurate representation of the population of all Korean immigrant women in the United States. The second limitation of this research study was that the participants' size was small ( $N = 58$ ) and the majority of participants were from south and central Texas. The participants in this study might not be considered to be representative of all other Korean immigrant women residing in different regions of the U.S. where Korean communities vary in size. The third limitation of this research study was the use of self-report measures which the participants may have responded to in a socially desirable way. Socially desirable or acceptable responding from participants would modify the statistical results of the study. The fourth limitation of this research study was the participants in the intervention group already had a close relationship or friendship with other participants in the intervention group before. It is possible that the participants had limited expression and sharing their feeling and experience. The fifth limitation of this research study was the control group may have received a treatment, coloring, which was shown to be related to reduced anxiety (Curry & Kasser, 2005; Vennet & Serice, 2012). The sixth limitation of this study was the study was limited to a three-week period. It is not clear how long lasting any effects of the expressive intervention counseling experience will be on the depressive symptoms in the Korean immigrant participants. It is possible that the decrease in depressive symptoms will be short term, but the decrease also could be long term. The last limitation of this study is that the dual roles of the researcher could have affected the results of the study. Even though the participants in the intervention group were blind to the fact that they were in the intervention group for this study, the participants in the intervention group might have provided desirable responses on the post-



test to please the group facilitator to express their appreciation for having the expressive group counseling interventions.

### **Definition of Terms**

*Acculturative stress:* Berry (1997) described acculturative stress as “a stress reaction in response to life events that are rooted in the experience of acculturation” (p.19) that include containing pressure, tension, and stress during the acculturation period and potentially increasing dangerous effects on the immigrants’ physical and mental health (American Psychological Association, Presidential Task Force on Immigration, 2012; Berry 1997; Rudmin, 2009).

*Depressive symptoms:* Depressive symptoms are emotional, cognitive, and physical changes that include: feelings of depression, guilt, sadness, hopelessness, worthlessness; loss of interest in usual activities; inability to experience pleasure; thoughts of suicide; poor concentration; difficulty thinking; inability to make decisions; memory loss; distractibility; changes in sleep, appetite, and behaviors; lack of energy; feeling either restless or slow; fatigue; digestive problems; and headaches (American Psychiatric Association, 2013; Gellman & Turner, 2013a, 2013b).

*Korean woman:* A Korean woman is a female human adult who was born in South Korea or at birth obtained South Korean citizenship, was raised primarily in Korean culture, and whose family is from South Korea.

*Immigrant:* An immigrant is an individual who moved his or her residence to a different country, for this study the United States. When the individual moved to the United States, he or she was not considered a native and did not possess citizenship.

*Expressive interventions:* Expressive interventions are therapeutic activities that use such expressive modalities as drawing, art, integrated arts, music, drumming, cinema, drama, storytelling, writing, creative movement, play, and sandtray therapy with individuals of all ages

to assist in the expression of emotions and thoughts (Bradley, Whiting, Hendricks, Parr, & Jones, 2008; Malchiodi, 2005).

*Group counseling:* Group counseling is a form of counseling where two or more individuals meet regularly to interact and connect with others and the group leader (Bussmann, 2014; Forsyth, 2010; Gladding, 2016a). Group counseling is “the development of an interpersonal network” (Trotzer, 2013, p. 20) that creates an atmosphere of trust and acceptance to link and work together between each member to one another and the whole group (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

*Southern and Central Texas:* Counties include Bexar, Guadalupe, Comal, Hays, and Travis counties.

## **CHAPTER II: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

In this chapter a review of relevant literature and the conceptual framework for this research study is presented. A conceptualization of stress, including definitions of stress, different characteristics of stress, and theoretical approaches for understanding the development of stress, is offered. How stress affects a person's physical and psychological health is examined, and ways of coping with stress are considered. This chapter reviews the stressful life experiences of immigrants, particularly Korean women who have immigrated to the United States. Counseling techniques for working with Korean women are discussed, and the applicability of Gestalt therapy, particularly in a group format and using expressive techniques to reduce depressive symptoms and acculturative stress is examined.

### **Stress**

Life continually creates stress and people may automatically think that stress is something negative in daily life. Hans Selye, internationally acknowledged as the father of stress research (Roskies, 1991; Shaffer, 1982), suggested stress is not always bad (Selye, 1975, 1976a). According to Selye (1975), stress is "the spice of life" (p.83) and can have either beneficial or harmful effects (Critelli & Ee, 1996; Cronholm, 1976; Lazarus, 1993; Lazarus & Folkman, 1984; Selye, 1975, 1976a, 1976c, 1991; Szabo, Tache, & Somogyi, 2012). Just as not enough spice leaves food bland, not enough stress can lead to an unsatisfying life. Similarly, too much spice or the wrong spice can ruin the dish, and too much stress or the wrong type of stress can cause problems in life.

When stress occurs within a situation where individuals feel secure, comfortable, or in control, stress can benefit the individuals by increasing their energy levels and motivation, which might have the effect of raising performance and producing greater ability to accomplish

challenges (Le Fevre, Matheny, & Kolt, 2003; O'Sullivan, 2011; Walinga, 2014). This stress is called positive stress, also known as eustress (Le Fevre et al., 2003; O'Sullivan, 2011; Parker & Ragsdale, 2015; Walinga, 2014). According to Nelson and Simmons (2011), eustress is “a positive psychological response to a stressor, as indicated by the presence of positive psychological states” (p. 59). The positive stress will motivate and encourage accomplishment of daily challenges (Critelli & Ee, 1996; Cronholm, 1976; Lazarus, 1993; Lazarus & Folkman, 1984; as cited in Le Fevre et al., 2003; McGowan, Gardner, & Fletcher, 2006; Selye, 1975, 1976c; Szabo et al., 2012; Wolf, 1976). However, if individuals face stress within circumstances where challenges continuously occur or last longer than expected, the individuals might experience negative symptoms such as fatigue (Parker & Ragsdale, 2015; Parrish, Zautra, & Davis, 2008; Zohar, Tzischinski, & Epstein, 2003), anger, tension, and dissatisfaction (Nelson & Simmons, 2011). These negative reactions are referred to as distress (Critelli & Ee, 1996; Cronholm, 1976; Lazarus, 1993; Lazarus & Folkman, 1984; as cited in Le Fevre et al., 2003; McGowan et al., 2006; Parker & Ragsdale, 2015; Selye, 1975, 1976c; Szabo et al., 2012; Walinga, 2014; Wolf, 1976). According to Goldstein and Kopin (2007), distress is “cognitive recognition of a condition that is aversive to the organism, as evidenced by motivation for learning to escape or avoid the stressor” (p.115).

When distress becomes overwhelming, it can damage a person's health, emotions, mood, relationships, achievements, abilities, and quality of life (Dohrenwend & Dohrenwend, 1974b; Fink, 2016; Lazarus, 1993; Lazarus & Folkman, 1984; Lyon, 2000; Nelson & Simmons, 2011; Steptoe, 2007; Rahe & Arthur, 1987; Setterlind & Larsson, 1995; Terrie, 2010; Thoits, 2010). Therefore, individuals need to understand how they physically and mentally respond to stress, and they need to develop applicable and appropriate coping skills for healthy and positive responses to stress. Managing stress using coping skills is necessary to help limit overall stress

and its negative effects (Dohrenwend & Doherenwend, 1974a; Monat, Lazarus, & Reevy, 2007; Selye, 1975, 1976a, 1976 b; Somerfield & McCrae, 2000).

### **Definitions of Stress**

Stress is an integral part of being, which demands people's attention possible every moment of their lives. Even though stress naturally occurs in everyday life (Selye, 1976a), it sometimes is overwhelming. According to Palmer and Cooper (2013a), stress appears “when pressure exceeds your perceived ability to cope” (p. 7). People experience stress when they are faced with environmental, social, or internal demands that cause them to need to readjust their normal behavior patterns (Holmes & Rahe, 1967; Thoits, 1995). For example, people may face devastating stress when they do not have solutions or resources for dealing with interpersonal problems (Falkum & Vaglum, 2005; Holmes & Rahe, 1967; Kato, 2015; Shaffer, 1982) or unexpected situations (Berlyne, 1976; Holmes & Rahe, 1967).

Early studies on stress originated from the biological sciences, such as physiology, biochemistry, and neurophysiology (Aldwin, 2007; Weber, 2011). Later, studies moved to social, psychological, and behavioral sciences, such as psychology and sociology (Aldwin, 2007; Li & Olsen, 2005; Weber, 2011). Even though researchers created numerous definitions of stress, the ideas of stress were still unclear and confused because the definitions of stress were too broad or limited (Li & Olsen, 2005). For example, Cannon (as cited in Cooper & Dewe, 2004a; as cited in Fink, 2010; as cited in Roskies, 1991), a physiologist, referred to stress as fight-or-flight responses that a person's body automatically makes during dangerous or life-threatening situations. In comparison, Cox (1978), a psychologist, defined stress as “a perceptual phenomenon arising from a comparison between the demand on the person and his or her ability to cope” (p. 25).

Scholars have looked at stress differently depending on their fields (Geber, 1996; Grant et al., 2003; Hammen, 2015; Palmer & Cooper, 2013a; Somerfield, & McCrae, 2000). A concise physiological definition of stress (Geber, 1996) is, “the nonspecific response of the body to any demand” (Selye, 1976a, p 1, p 74, 1976b, p. 137). This definition, Selye's definition of stress, has been cited by many authors (Fink, 2010; Geber, 1996; Kudielka & Kirschbaum, 2007; Li & Olsen, 2005; Levine, 1985; Robet-McComb & Young, 2011; Szabo et al., 2012). Lazarus and Folkman (1984) defined stress as a result of an imbalance “between demands and resources within the person, within the environment, and between the person and the environment” (p.114). According to Aldwin (2007), stress is a “quality of experience, produced through a person-environment transaction, that, through overarousal or underarousal, results in psychological or physiological distress” (p. 24). More recently, McEwen and Wingfield (2003) referred to stress as “events that are threatening to an individual and which elicit physiological and behavioral responses as part of allostasis in addition to that imposed by the normal life cycle” (p. 4).

There is no one universally accepted definition of stress because stress is a complicated concept (Monat et al., 2007) and has different meanings for different people under different situations (Dohrenwend & Doherenwend, 1974a; Somerfield & McCrae, 2000). For example, Lazarus, DeLongis, Folkman, and Gruen (1985) stated:

Stress is best regarded as a complex rubric, like emotion, motivation, or cognition, rather than as a simple variable. The meaning sphere of stress is defined by many variables and processes that are reflected in the person's appraisal of a relationship with the environment as relevant to well-being and taxing or exceeding his or her resources (p. 776).

Therefore, it is difficult to establish a definition for stress, because stress is a subjective and varied experience. However, there are several overlapping elements of the definitions of

stress. These elements indicate that stress is a personal experience that arises due to pressure and affects an individual's ability to cope. In this research study, stress is defined as a pattern of unwanted physiological and psychological reactions to threats to an individual's well-being (Lazarus & Folkman, 1984).

Generally, there are three types of stress: physiological, psychological, and social stress (Li & Olsen, 2005; Monat & Lazarus, 1991; Monat et al., 2007; Trumbull & Appley, 1986). In the physiological aspect of stress, stress is "concerned primarily with the disturbances of tissue systems" (Monat & Lazarus, 1991, p. 2). Physiological stress, also known as systemic stress, is a natural and automatic response in a person's body and tissue systems in response to danger or threatening events or situations (Lazarus, 2006, 2007; Monat & Lazarus, 1991; Monat et al., 2007; Trumbull & Appley, 1986; Yakushko, Watson, & Thompson, 2008). In the psychological aspect of stress, stress refers to pressures that affect thoughts and feelings that evaluate threat with cognitive factors which lead to negative effects on individual's cognition and emotional response (Kittay, Serban, Kolb, & Sabshin, 1976; Lazarus, 1993; Monat & Lazarus, 1991; Monat et al., 2007; Selye, 1976a; Trumbull & Appley, 1986). According to Monat and Lazarus (1991), psychological stress relates to "cognitive factors leading to the evaluation of threat" (p.2) and means different things to different people. Social stress is "the disruption of a social unit or system" (Monat & Lazarus, 1991, p.2). Researchers suggest that social stress comes with cultural differences that affect the person's judgment and interrupts social systems or social units (Knight, & Sliverstein, 2000; Lazarus, 2006, 2007; Monat & Lazarus, 1991; Monat et al., 2007; Rosenfarb, Bellack, & Aziz, 2006; Trumbull & Appley, 1986).

Stress results from the psychological or physiological imbalance between the situational demands and the individual's ability to meet those demands (Lazarus, 1993; Lazarus & Folkman, 1984; Monat & Lazarus, 1991; Monat et al., 2007). Many individuals are exposed to various

stressors from everyday life experiences. If the individuals do not appropriately cope or manage stress may result in severe consequences (Lazarus, 1993; Lazarus & Folkman, 1984; Monat & Lazarus, 1991; Monat et al., 2007).

### **Theoretical Approaches to Understanding Stress**

Several significant theoretical perspectives of stress, such as, biological (e.g., Cannon 1925, 1932; Selye 1976a, 1976b), psychological (e.g., Lazarus 1966,1993; Lazarus & Folkman 1984), and sociological (e.g., Dohrenwend & Dohrenwend, 1974a, 1974b) have been proposed since the 1950s (Cooper & Dewe, 2007; Lazarus, 1966, 2000, 2006, 2007). Through a review of stress studies, theoretical orientations in understanding stress have been primarily conceptualized and viewed from three perspectives, response, stimulus, and transaction (Brannon, Feist, & Updegraff, 2014; Lyon, 2000; Grant & McMahon, 2005; Matthieu & Ivanoff, 2006; Schwarzer & Luszczynska, 2012; Schwarzer & Taubert, 2002; Walinga, 2014). Historically, the three views of stress focus on the reaction, the environment, and on the interaction processes (Cooper, Dewe, & O'Driscoll, 2001; Cox, 1978; Devonport, 2013; Lazarus & Folkman 1984; Lyon, 2000; Monat & Lazarus, 1991; Roskies, 1991; Walinga, 2014).

It is important to recognize different theoretical perspectives of stress in order to understand how people deal with stress, and how people obtain skills to cope with stress (Walinga, 2014). Additionally, being conscious of the various perspectives of stress helps to determine individuals' reactions, adjustments, and coping strategies (Walinga, 2014). Therefore, I briefly address the concept of stress, the approach of stress, and the distinction of different perspectives, including response-based model, stimulus-based model, and transaction model of theories, in order to help gain a better understanding of the history and scope of stress in this section.



**Response-based model of stress.** The response-based model of stress focuses on the physiological or emotional patterns of response, which results from exposure to stressful situations (Cooper et al., 2001; Cox, 1978; Grant et al., 2014; Hobfoll, 1989; Hobfoll, Schwarzer, & Chon, 1998; Houston, 1987; Lazarus, 2006; Lazarus & Folkman 1984; Lyon, 2000; Monat, et al., 2007; Rice, 2000; Roskies, 1991; Salleh, 2008; Selye, 1975, 1976a; Schwarzer & Taubert, 2002; Walinga, 2014). According to Monat and Lazarus (1991),

the response-based definition of stress (e.g., one that looks at increased physiological activity as an indicator of stress) is suffering from, among other things, the fact that the same response pattern (such as increased blood pressure or heart rate) may arise from entirely different stimulus conditions, for example, heavy exercise or extreme fright. (p.2).

In the response-based theory, stress is seen as a response, and investigates pressure, or demands that the stressor develops any physiological consequences (Cohen et al., 1997; Cox, 1978; Lazarus, 2006, 2007; Lazarus & Folkman 1984; Lyon, 2000; Rice, 2000; Roskies, 1991; Selye, 1975, 1976a, 1976c; Schwarzer & Taubert, 2002; Singer & Davidson, 1986; Walinga, 2014). Additionally, the response-based model considers stress as “the reaction of the organism to some sort of outside threat” (Singer & Davidson, 1986, p. 44).

Hans Selye initially established the response-based theory of stress and essentially focused on physiological definition (Cooper et al., 2001; Cox, 1978; Lazarus & Folkman 1984; Lyon, 2000; Rice, 2000; Roskies, 1991; Selye, 1975, 1976a, 1976c; Schwarzer & Taubert, 2002; Singer & Davidson, 1986). Selye coined the word stress which is a pathfinder of modern stress theory (Fink, 2010; Geber, 1996; Kudielka & Kirschbaum, 2007; Li & Olsen, 2005; Levine, 1985; Robet-McComb & Young, 2011; Roskies, 1991; Shaffer, 1982). He, an endocrinologist and a physician, established the concept of biological stress and developed a physiological and

medical perspective of stress (Lyon, 2000; Shaffer, 1982; Taché & Brunnhuber, 2008). Selye (1975, 1976c) also developed one of the first systematic descriptions of stress responses. Selye (1976a) also distinguished between a stressor, which is the stimulus, and stress, which is a response, through his studies (Lazarus & Folkman 1984; Lyon, 2000; Monat & Lazarus, 1991; Singer & Davidson, 1986).

Selye initially began his research by looking at the relationship between a physiological change to various physical stressors such as pain, cold, or heat (Moberg, 1985; Robet-McComb & Young, 2011; Selye, 1976a, 1976b). He discovered that common sets of responses existed to various stressors after numerous experiments on animals (Kudielka & Kirschbaum, 2007; Robet-McComb & Young, 2011). He recognized that there were remarkably similar physiological responses to different types of stressors (Lazarus & Folkman 1984; Lyon, 2000; Roskies, 1991; Moberg, 1985; Robet-McComb & Young, 2011; Selye, 1975, 1976a, 1976b; Szabo et al., 2012). Selye (1975, 1976a, 1976b, 1976c) concluded that stress is a general response to people's bodies when faced with unusual or extraordinary demands (as cited in Geber, 1996).

Selye (1976a) defined stress as “the state manifested by a syndrome which consists of all the nonspecifically induced changes in a biologic system” (p.64). Selye (1975, 1976a, 1976c, 1991) also viewed stress as a response, an organized set of hormonal and tissue changes to any form of noxious stimuli or environmental stressors (Lazarus & Folkman 1984; Lyon, 2000; Roskies, 1991; Singer & Davidson, 1986). Selye (1975, 1976a, 1976c, 1991) described three predictable stages that the body uses to respond to stressors known as the General Adaption Syndrome (Cooper et al., 2001; Cox, 1978; Lazarus & Folkman, 1984; Selye, 1975, 1976a, 1976c, 1991).

General Adaption Syndrome (GAS) proceeds in three stages of stress response, which are the alarm reaction, the stage of resistance, and the stage of exhaustion (Cooper et al., 2001; Cox,

1978; Devonport, 2013; Lazarus & Folkman, 1984; Rice, 2000; Selye, 1975, 1976a, 1976c, 1991; Schwarzer & Taubert, 2002; Walinga, 2014). The first stage has been called the alarm reaction in which the body makes its initial response. The alarm reaction involves an initial shock phase and countershock phase (Cooper et al., 2001; Cox, 1978; Devonport, 2013; Lazarus & Folkman, 1984; Rice, 2000; Selye, 1975, 1976a, 1976c, 1991; Schwarzer & Taubert, 2002; Walinga, 2014). The shock phase exhibits the initial and immediate result of the noxious agent on tissues (Cooper et al., 2001; Devonport, 2013; Lazarus & Folkman, 1984; Rice, 2000; Schwarzer & Taubert, 2002; Walinga, 2014). The countershock phase shows the action of defensive processes on the part of the physiological system (Lazarus & Folkman, 1984). If the body is confronted with a noxious agent and continuous exposure to life, but the organism can survive, the organism enters the second stage, which is called the stage of resistance or the stage of adaptation (Cooper et al., 2001; Cox, 1978; Devonport, 2013; Lazarus & Folkman, 1984; Selye, 1975, 1976a, 1976c, 1991; Schwarzer & Taubert, 2002; Walinga, 2014). During this stage, the body primarily “increase[s] resistance to stressor agent and decrease[s] resistance to other stimuli” (Lazarus & Folkman, 1984, p. 99). Thus, the body attempts to return physiological functions to normal while it resists decreasing other kinds of stressors at the same time (Cooper et al., 2001; Cox, 1978; Lazarus & Folkman, 1984; Selye, 1975, 1976a, 1976c, 1991; Walinga, 2014). Finally, the body enters a third stage, the stage of exhaustion, when the stressor has exhausted the body's capability of adapting. It can be associated with permanent damage on the body and tissue that appear as, diseases, illness, depression, or even death (Cooper et al., 2001; Cox, 1978; Devonport, 2013; Lazarus & Folkman, 1984; Selye, 1975, 1976a, 1976c, 1991; Schwarzer & Taubert, 2002).

Selye's work on stress contributed to and greatly influenced many researchers who studied the development of stress and the understanding of stress. His theory is still dominant in

the science fields today. However, the response-based approach ignored the role of emotions and cognitions on humans by focusing only on animals. According to Schwarzer and Taubert (2002), “[Selye’s view] is no longer supported in psychology, mainly because Selye has disregarded the role of emotions and cognitions by focusing solely on physiological reactions in animals and humans” (p. 20). Additionally, Selye did not take into account coping skills for stress and claimed that all humans show a similar nonspecific response to any threats or changes without paying attention to how the situation is perceived (Schwarzer & Taubert, 2002).

**Stimulus-based model of stress.** The stimulus-based model of stress was introduced in the 1960s (Lyon, 2000; Walinga, 2014), which identifies stress as the nature of the stimulus, as opposed to response (Cooper et al., 2001; Lazarus, 2006, 2007; Lazarus & Folkman 1984; Hobfoll, 1989; Holmes & Rahe, 1967; Lyon, 2000; Monat & Lazarus, 1991; Schwarzer & Taubert, 2002; Walinga, 2014). Stress is defined as a stimulus, life events, or a set of occurrences that produce physiological and/or psychological reactions that may develop the people’s vulnerability (Cooper et al., 2001; Lazarus, 2006, 2007; Lazarus & Folkman 1984; Hobfoll, 1989; Hobfoll et al., 1998; Holmes & Rahe, 1967; Lyon, 2000; Monat & Lazarus, 1991; Schwarzer & Taubert, 2002; Walinga, 2014).

The stimulus-based model views some external forces as threats that impact the human in a disrupting system (Cooper et al., 2001). This model focuses on the function of the environment in creating stress. Additionally, the stimulus-based theory deems significant life events or certain situations that require to change, adjust, or adapt are causes of stress (Cooper et al., 2001; Lazarus & Folkman 1984; Hobfoll et al., 1998; Holmes & Rahe, 1967; Lyon, 2000; Monat & Lazarus, 1991; Schwarzer & Taubert, 2002; Walinga, 2014). For example, external stressors or environmental situations such as workload, divorce, death of a loved one, heat and cold, and time pressure (Cooper et al., 2001; Grant et al., 2003; Lazarus & Folkman 1984; Hobfoll et al., 1998;

Holmes & Rahe, 1967; Houston, 1987; Lyon, 2000; Monat & Lazarus, 1991; Salleh, 2008 Schwarzer & Taubert, 2002; Walinga, 2014) develop stress that “typically disturb or disrupt the individual” (Houston, 1987, p. 376).

In contrast to the response-based model, the stimulus-based model “[pay] more attention to the particular characteristics of the stressor” (Schwarzer & Taubert, 2002, p.20) rather than physiological responses or reactions. Additionally, the stimulus-based model views stress as an independent variable that reflected the source of an experience instead of the experience itself, unlike the response-based approach (Cooper et al., 2001; Frost & Werner, 2000; Lyon, 2000; Walinga, 2014). For example, Holomes and Rahe (1967) suggest stress occurs due to exposure of any environmental, social, or internal needs that ask an individual to readjust or change his or her usual behaviors, characters or performances (Grant et al., 2003; Park, 2007; Thoits, 1995).

Two psychologists, Thomas Holmes and Richard Rahe, were interested in people’s experiences on the changes in life circumstances or conditions and proposed a stimulus-based approach of stress (Holomes & Rahe, 1967; Holmes & Masuda, 1974). Holmes and Rahe (1967) believed that stressful life experiences can be potential threats to emotional, physical, or psychological well-being and health. Luthar (as cited in Wong, 2008) stated that stressful life events could be conceptualized as the cause of risks that a person experienced, potentially extending inadequate mental health outcomes.

Holmes and Rahe (1967) focused on life events and the pattern of living that could be associated with or create changes in health systems or conditions. Holmes, Rahe, and their colleagues reported evidence that many illnesses develop or increase for a period of time during and following stressful life changes that require major coping actives (Monat & Lazarus, 1991). Researchers have linked emotional and life stress to the onset of such chronic diseases as

coronary heart disease and hypertension (Holmes & Masuda, 1974; Holmes & Rahe, 1967; Porta, 2014; Rahe, 1972, 1974; Rahe & Arthur, 1987; Rahe, Meyer, Smith, Kjaer, & Holmes, 1964).

Holmes and Rahe (1967) conducted research that studied the relationship between stressful life events and illness. They measured “life stress” (Holmes & Rahe, 1967, p. 213) regarding social or life events that may or may have caused illness during their research. The researchers asked their participants to rank a series of life events that need readjustment. They surveyed 394 medical patients: 179 males and 215 females; 363 were White participants, and 19 were African American participants. In the study, the participants completed the paper-and-pencil questionnaire, which is referred to as the Social Readjustment Rating Scale (SRRS).

The Social Readjustment Rating Scale (SRRS) was developed by Holmes and Rahe (1967) to measure “how recent events in a person’s life have changed his/her lifestyle, and hence the degree of stress she/he might be expected to experience” (Stuart-Hamilton, 2007, p.247). The SRRS is a self-administered questionnaire that a person “uses to report whether any of the indicated life changes have occurred during the past few months or years” (Monat & Lazarus, 1991, p.14). The SRRS, is a list of 43 life events that were emphasized by Meyer (as cited in Holmes & Rahe, 1967), and have been identified from clinical psychological experiences as being stressful. The SRRS was created to identify and rank major significant stressful life events, including changes of individual circumstances, death of a spouse, loss of job, retirement, relocation, marriage, pregnancy, divorce, a change in job, and a natural disaster that fundamentally influences the environment (Cooper & Dewe, 2004a; as cited in Cooper & Dewe, 2007; Frost & Werner, 2000; Holmes & Rahe, 1967; Porta, 2014; Walinga, 2014). Points are scored for each of the stressful life events, from “death of a spouse,” (Holmes & Rahe, 1967, p.216) which is the most stressful on the list, to “a minor violation of the law” (Holmes & Rahe, 1967, p.216), which is the least stressful on the list.

Holmes and Rahe (1967) discovered a list of common causes of stress, for the most common stressful experiences. In their research, they found that the forty-three life events were associated with adaptive behavior on the part of the individual involved in the experiences. They also focused on the objectively assessable changes in individuals' social environment or in environmental conditions that were associated with substantial adaptive demands (Cohen et al., 1997; Dohrenwend & Dohrenwend, 1974a, 1974b; Frost, & Werner, 2000; Grant et al., 2003; Holmes & Rahe, 1967; Salleh, 2008; Schwarzer & Taubert, 2002; Walinga, 2014).

Each life event on the checklist was indicated as a stressful situation, including desirable, undesirable, controllable, or uncontrollable events. The researchers indicated that stressful life events evoked psychophysiological reactions and that are associated with many diseases. According to Holmes and Rahe (1967), "the life chart device has been used systematically in over 5000 patients to study the quality and quantity of life events empirically observed to cluster at the time of disease onset" (p. 215). Holmes and Rahe (1967) showed correlations between SRRS scores and illnesses, such as heart attacks, diabetes, complications of pregnancy and birth, and other difficulties. Additionally, Holmes and Rahe (1967) indicated in their research that stressful life events, such as both positive and negative changes, played an important and relevant role, and could have an impact on a person's health. Stressful life events also have a history of being involved in many diseases because the life events probably "demand adjustments by the individual to a new life style or pattern" (Monat & Lazarus, 1991, p. 14). Even though there was some evidence of a correlation between stressful life events and physical or psychological illness, the major criticism and argument has been identified in the stimulus-based approach as ignoring important variables, such as individual personality, individual differences in responding to the same potentially stressful circumstances, and prior life

experience (Cooper & Dewe, 2004a; Cox, 1978; Papathanasious, Tsaras, Neroliatsiou, Roupa, 2015; Schwarzer & Luszczynska, 2012; Schwarzer & Taubert, 2002; Walinga, 2014).

**Transactional model of stress.** The perspective of stress has moved from the response and/or the stimulus models of stress, to the transitional model of stress in the 1960s and 1970s (as cited in Cooper & Dewe, 2007; Lazarus, 1966; Lazarus, 2000, 2006, 2007). Even though stress was conceptualized within the field of psychology, by the end of the 1950s (Cooper & Dewe, 2004b), behaviorism was a prominent perception in the psychology until late 1950s (Viney & King, 2003). The stress perspective that was defined by behaviorists was the center of attention in the early years of the twentieth century (Cooper & Dewe, 2004b). However, there was increased agreement that the concept of stress presented by behaviorists was "too narrow, and that methodologically and substantively, they had closed too many doors" (Viney & King, 2003, p.326) in the 1960s (Cooper & Dewe, 2004b). Psychologists turned their attention to a new look at the psychology of mind and behavior (Lazarus, 2006). According to Lazarus (2006), many psychologists began to study "...a broad range of phenomena and processes not countenanced by radical behaviorism" (p.7). These psychologists also developed "subjective theories of stress" (Lazarus, 2006, p. 7) and emphasized emotional experience that centered on "how people appraise the circumstances of their lives" (Lazarus, 2006, p. 7).

At the beginning of the 1960s, psychologists began to view stress as a transaction between the environment and the individual. Psychologist Richard Lazarus became interested in how individuals differ in relation to stress and coping with stress (Lazarus, 1966, 1993; Lazarus & Folkman, 1984). Additionally, Lazarus (1966) was interested in a particular relationship between a person and an environment. He contended that stress exists as a result of transactions between the person and his or her environment, rather than simply as the result of an event. Lazarus



(1966) also described stress as “a condition or feeling experienced when a person perceives that demands exceed the personal and social resources that the individual is able to mobilize” (p. 4).

Folkman and Lazarus (1980,1985) reviewed and evaluated the previous two theories, response, and stimulus models of stress, mentioned above which considered a person as a machine (Lazarus, 1966, 1993; Lazarus & Folkman, 1984). They believed that each individual has an ability to think, evaluate, and then react to the stress (Folkman & Lazarus, 1985,1980; Lazarus, 1966, 1993; Lazarus, Deese, & Osler, 1952; Lazarus & Folkman, 1984). The new psychology movement emphasized “individual difference in perception” (Lazarus, 2006, p. 7) and recognized that individuals could differ from “the perceptual norm or standard without necessarily suffering from psychopathology” (Lazarus, 2006, p. 8).

Lazarus and his colleague Folkman (1984) proposed a transactional model of stress, which emphasizes “the person and the environment in a dynamic, mutually reciprocal, bidirectional relationship” (Lazarus & Folkman, 1984, p.293). Lazarus and Folkman (1984) defined stress, especially psychological stress, as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19). A fundamental proposition of the transactional model, which is stress as a product of an interaction between a person and his or her intricate environment (Lazarus, 1966; Lazarus et al., 1985; Lazarus & Folkman 1984; Matthieu & Ivanoff, 2006) was rarely discussed by response and/or stimulus theorists. This model also states that stress is caused by a transaction between an individual’s view of the stressor and his or her perceived ability to manage with it (Lazarus, 1966; Lazarus et al., 1985; Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) believed that each person has the capability or ability to think, evaluate, and react to threat, harm, or challenges. Lazarus (1993) and his colleagues

learned that stressful conditions did not create “dependable effects” (p. 3) from their work. They discovered that how a person responded to stressful conditions did not indicate that another person would react in the same way (Lazarus, 1993; Lazarus et al., 1952). For example, one individual might produce a great performance under stress while another might do a lesser performance when given the same stressful conditions (Lazarus, 1993; Lazarus et al., 1952). Lazarus (1993) and his colleagues concluded that “individual difference in motivational and cognitive variables” (p. 3) led the individual's reaction to the stressors. According to Monat & Lazarus (1991), the stimulus-based approach defined stress as “any situation may or may not be stressful, depending on characteristics of the individual and the meaning of the situation for him or her” (p. 2).

### **Causes of Stress**

According to Wethington (2016), stress contains a stressor. Studies on stress have shown that many factors in individuals' lives cause stress. It recognized that disclosure to stressors in daily life “may be one of the most critical components of health and well-being” (Wethington, 2016, p.103). According to Salleh (2008), any elements including any events, experience, or environmental stimuli, which create stress, are called stressors.

Stressors occur when individuals encounter any demand or event that “overwhelms [them] or disturbs [their] equilibrium” (Cook et al., 2011, p.124). Stressors are demands that are created by internal or external environments (Lazarus & Folkman, 1984). They affect the imbalance of individuals' physical and psychological well-being (Anisman, 2015a, 2015b; Lazarus & Cohen, 1977; Lazarus & Folkman, 1984). Grant et al. (2003) defined stressors as “environmental events or chronic conditions that objectively threaten the physical and/or psychological health or well-being of individuals of a particular age in a particular society” (p. 449). Another definition of stressor is a “physical or emotional, chronic or episodic, and/or single

factor or additive” (Ngo & Le, 2007, p. 75). For example, a stressor occurs when an individual's body experiences force to operate and has a lack of capacities, such as physical injury, physical abuse, trauma or physical exertion (McEwen, 2007, 2016). Noise, overcrowding, extreme hearing, or cold could be physical stressors (McEwen, 2016). Psychological suffering includes "time-pressured tasks, interpersonal conflict, unexpected events, frustration, isolation and loneliness, and traumatic life events" (McEwen, 2016, p. 42) and involves stressors (McEwen, 2007). Additionally, stressors often include a sort of change in the social environment or condition that usually require individuals' ability to adapt (Ngo & Le, 2007).

According to Park (2007) and Thoits (1995), stressors have been divided into three significant forms of stressor, which include life events, chronic strains, and daily hassles in the studies. First, life events involve a discrete incident, circumstance, or occurrence that can interrupt an individuals' life, may require adjustment and can be associated with or result in emotional and physical change (Surtees & Wainwright, 2007). The life events are “acute changes” (Thoits, 1995, p.54) that demand “major behavioral readjustments” (Thoits, 1995, p.54) within a comparatively short period. For example, life events can be the first birth, divorce, or change in residence. Second, chronic strains or stressors are continuous or repeated demands that require readjustments over prolonged periods of time (Park, 2007; Serido, Almeida, & Wethington, 2004; Thoits, 1995). Pearlin (as cited in Serido et al., 2004) identified chronic strains as a stressor, which associates with an interaction of individual and any circumstances “encountered in carrying out the responsibilities of major social roles “(p. 18). For example, chronic strains are major personal illnesses, disabling injury, poverty, or marital problems (Thoits, 1995). Daily hassles are referred to as relatively minor life events that require small behavioral readjustments within a day or two (Serido et al., 2004; Thoits, 1995; Wethington, 2009). Such minor life events could be small or unexpected events that may interrupt daily life.

For example, unexpected work deadlines, traffic, arguments with kids, or unexpected visitors can be daily hassles (Serido et al., 2004; Thoits, 1995).

### **Stress and Health**

According to Cohen et al. (1997), stress is considered an influencer in the pathogenesis of physical diseases by causing negative affective states. The negative affective stress directly impacts biological processes and behavioral patterns that effect disease risk in general. Salleh (2008), Schneiderman, Ironson, and Siegel (2005) stated that defining a relationship between stress and illness is complicated due to several factors that influence susceptibility to stress. The factors that influence the relationship between stress and illness include the nature, number of times it has occurred, genetic vulnerability, coping patterns, lifestyle, general socioeconomic status, type of personality and social support (Institute of Medicine, 2001; Salleh, 2008; Schneiderman et al., 2005). However, if an individual is exposed to acute or chronic stress for an extended period of time, the individual is exposed to a high risk of emotional and physical disease or illness.

According to Selye (1976b), stress is “a cause of disease [that] has often been invoked in the courts to support the cases of plaintiffs who developed various illnesses following exposure to unusual demands for adaptation, especially at work or in concentration camps” (p. 1164). Many studies have been conducted to investigate the relationship between stress and illness, and to find out the effect of stress on physiological health (Anisman, 2015c; Cohen et al., 2007; Critelli & Ee, 1996; Dougall & Baum, 2001; Frost & Werner, 2000; Hobfoll et al., 1998; Holmes & Masuda, 1974; Lazarus & Folkman, 1984; Karademas, Karamvakalis, & Zarogiannos, 2009; Lerner, 1996; Li & Olsen, 2005; McEwen, 2008; Rahe & Arthur, 1987; Rahe et al., 1964; Rice, 2000; Salleh, 2008; Selye, 1976b; Schneiderman et al., 2005; Slavich, 2016; Surtees & Wainwright, 2007; Terrie, 2010).

The results of these studies indicate that stress is potentially a significant contributor to illness (Cohen & Herbert, 1996; Cohen, Tyrrell, & Smith, 1991; Hermann, Beck, & Sheridan, 1995; Kiecolt-Glaser, Glaser, Gravenstein, Malarkey, & Sheridan, 1996; McEwen, 1998; Selye, 1976b; Slavich, 2016; Slavich & Irwin, 2014). For example, individuals under chronic stress can experience a change in the emotional, physiological, and behavioral responses that affect the susceptibility to, and progress of, disease (Cohen et al., 1997; McEwen, 1998). According to Cohen et al. (1997), individuals may change their behavioral reactions such as increased drinking, decreased sleep, or stopping exercise while adopting or managing the stressors which can cause results to alter or break the regulation of immune and inflammatory function because the stress reaction is “an important component of the body’s regulatory systems” (Institute of Medicine, 2001, p. 40).

In addition, researchers have recognized that stress has been linked to the onset of diseases such as cardiovascular conditions (Arnold, Smolderen, Buchanan, Li, & Spertus, 2012; Benschop et al., 1998; Buchhorn, Meint, & Willaschek, 2016; Dimsdale, 2008; Nash, 1999; Pashkow, 1999; Selye, 1970; Steptoe & Kivimäki, 2012, 2013; Steptoe, Rosengren, & Hjemdahl, 2012), cancer (Antoni et al., 2006; Antonova, Aronson, Mueller, 2011; Cohen & Rabin, 1998; Denaro, Tomasello, & Russi, 2014; Johansen, Sørensen, Høeg, Bidstrup, & Dalton, 2017; Kiecolt-Glaser & Glaser, 1999; Sephton & Spiegel, 2003; Soung & Kim, 2015; Vasile, 2016), asthmas (Arcaya, Lowe, Rhodes, Waters, & Subramanian, 2014; Runeson-Broberg & Norbäck, 2014; Wood, Miller, & Lehman, 2015; Wright, Rodriguez, & Cohen, 1998), diabetes (Harris et al., 2017; Inui et al., 1998; Steptoe, 2016; Surwit, Schneider, & Feinglos, 1992), and skin disorders (Chiu, Chon, & Kimball, 2003; Gupta & Gupta, 2017; Kimyai-Asadi & Usman, 2001; Sandoval & Ayres, 2017; Tareen & Tareen, 2017).

### **Effects of Stress Outside of Health**

Stress is a part of a person's life and affects an individual in varied ways (Terrie, 2010). Stress could either be beneficial or harmful. For example, stress motivates a person to perform well at work or to successfully achieve his or her goals when the stress positively affects the person. An individual perceives stress as a positive stimulant when stress helps him or her manage an unpleasant situation or event (Anisman, 2015a, 2015b; Palmer & Cooper, 2013b; Terrie, 2010). If stress only positively impacts individuals, people may not need to know how to cope or manage their stressors. However, many individuals are becoming emotionally disturbed and unable to deal with stress, even under minor stressful situations. Some experience more stress than others and have more difficulty handling the stressors (Palmer & Cooper, 2013b; Terrie, 2010).

Many health-related disciplines such as psychology, sociology, mental health, nursing, and medicine examined the impact and symptoms of stress on an individual's well-being. According to researchers, the effects of stress are commonly predictable in four different areas: emotional, cognitive, behavioral, and physiological reactions (Anderson, 2013; Baum, Gatchel, Schaeffer, 1983; Breslau, 2002; Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002; Dahlin & Runeson, 2007; Dohrenwend & Dohrenwend, 1974b; Fink, 2016; Goldstein & Kopin, 2007; Grant, Compas, Thurm, McMahon, & Gipson, 2004; Lazarus, 1966; Lazarus & Folkman, 1984; Lyon, 2000; Nelson & Simmons, 2011; Steptoe, 2007; Rahe & Arthur, 1987; Setterlind & Larsson, 1995; Thoits, 2010; Zohar et al., 2003).

First, the emotional symptoms during stress include avoiding others, having difficulty relaxing or feeling in control, and being able to manage frustration and anger (Benson & Karlof, 2009), anxiety (Bener, Saleh, Bakir, & Bhugra, 2016; Byrne, Davenport, & Mazanov, 2007; Center for Disease Control and Prevention, National Institute for Occupational Safety and Health,

2002; Fink, 2016; Lester & Mander, 2015; McLaughlin & Hatzenbuehler, 2009; Moksnes, Espnes, & Haugan, 2014; Moksnes & Lazarewicz, 2017), depression (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002; Charbonneau, Mezulis, & Hyde, 2009; Cohen, Janicki-Deverts, & Miller, 2007; Kessler, 1997; Mezo & Baker, 2012; Moksnes & Lazarewicz, 2017; Moksnes, Moljord, Espnes, & Byrne, 2010; Steinhardt, Smith Jaggars, Faulk, & Gloria, 2011), or having depressive symptoms (Avison & Turner, 1988; Bener, Saleh, Bakir, & Bhugra, 2016; Jones et al., 2017; Lester & Mander, 2015; Moksnes et al., 2014) which may develop into a chronic mental disorder. Additionally, individuals may experience guilt, grief, denial, fear, irritability, loss of emotional control, or a sense of failure during or after stressful incidents (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002).

Second, the cognitive symptoms of stress include confusion, nightmares, disorientation, and heightened or lowered alertness (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002). Individuals may be experiencing cognitive symptoms such as concentration problem (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002; Elfering et al., 2017), difficulties in making decisions (Albertsen, Nielsen, & Borg, 2001; Elfering et al., 2017), lowering or losing memory function (Albertsen et al., 2010; Bremner, Krystal, Southwick, & Charney, 1995; Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002), lack of predictability (Albertsen et al., 2001; Albertsen, Rugulies, Garde, & Burr, 2010), and a speech impediment. Third, individuals experience the behavioral stress symptoms of addictive behavior, such as increased alcohol consumption (Becker, 2012; Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002; Kaysen et al., 2011; Robert et al., 2017), substance abuse (Rashid, Mustafa, & Asif, 2017; Robert et al., 2017; Rose

& Bond, 2008; Wu et al., 2016), risky sexual behavior (Wu et al., 2016) or change in sexual functioning (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002), and excessive gambling (Afifi, Brownridge, MacMillan, & Sareen, 2010; Robert et al., 2017).

Lastly, the physiological symptoms of stress include dry mouth, problems swallowing, itching, stomach pain, chest pain, difficulty breathing, profuse sweating, thirst, rapid heart rate, and nonspecific aches and pains (Center for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2002). Additionally, researchers reported other physiological symptoms such as headache (Buse & Lipton, 2015; Davis, Holm, Myers, & Suda, 1998; Dermitt & Friedman, 1987; Fanciullacci, Allessandri, & Fanciullacci, 1998; Goldstein & Kopin, 2007; Holm, Lokken, & Myers, 1997; Holroyd, Nash, Pingel, Cordingley, & Jerome, 1991), irritable bowel syndrome (Bennett, Tennant, Piesse, Badcock, & Kellow, 1998; Chang et al., 2014; Dancey, Taghavi, & Fox, 1998; Pellissier & Bonaz, 2016), insomnia symptoms (Palagini et al., 2016; Straus, Drummond, Nappi, Jenkins, & Norman, 2015; Vgontzas et al., 1998; Woodward et al., 2017), and fatigue (Goldstein & Kopin, 2007; Palmer et al., 2014; Parker & Ragsdale, 2015; Parrish et al., 2008).

### **Depression and Depressive Symptoms**

According to the U.S. Department of Health and Human Services, National Institutes of Health, and National Institute of Mental Health (2015), depression is one of the most common but potentially serious mood disorders and is “a normal reaction to difficult times in life and usually passes with a little time” (p. 3). The World Health Organization (2017) stated that the total number of people with depression was more than 300,000,000 worldwide in 2015. According to the American Psychiatric Association (2013), depressive symptoms include not only depressed mood but also the loss of interest or pleasure in nearly all activities. Individuals



who experience depressive symptoms often describe feeling depressed, sad, hopeless, discouraged, or down in the dumps.

Depression is distinct from usual mood fluctuations, such as normal emotional responses to loss or life challenges. Depression negatively impacts an individual's feelings, thoughts, and behaviors (American Psychiatric Association, 2013; Gellman & Turner, 2013a; U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 2015; World Health Organization, 2017). Depression is "a cluster of behaviors and symptoms that have both mental and physical manifestations and affect a wide range of functionality" (Gellman & Turner, 2013a).

Depressive symptoms can be categorized into three groups: emotional, cognitive, and physical symptoms (American Psychiatric Association, 2013; Gellman & Turner, 2013b). First, emotional symptoms include: (1) feelings of depression, guilt, sadness, hopelessness, worthlessness, (2) loss of interest in any usual activities, (3) inability to experience pleasure, and (4) thoughts of suicide (American Psychiatric Association, 2013; Gellman & Turner, 2013). Secondly, cognitive symptoms include: (1) poor concentration, (2) difficulty thinking, (3) inability to make decisions, (4) memory loss, and (5) distractibility (American Psychiatric Association, 2013; Gellman & Turner, 2013). Lastly, physical symptoms include: (1) changes in sleep, appetite, and behaviors, (2) lack of energy, (3) feeling either restless or slow, (4) fatigue, (5) digestive problems, and (6) headaches.

The depressive symptom can impair functioning if it is not addressed. Moreover, there is an increased risk for suicide and suicidal behaviors. Individuals may also engage in additional risk-taking behaviors, such as drug and alcohol use. Therefore, it is essential that depressive symptoms are addressed, and individuals learn to cope with these symptoms when they are present since they can be detrimental to a person's well-being and safety. King, Strunk, and

Sorter (2011) conducted a survey with 1030 high school students who were part of surviving the Teens Suicide Prevention and Depression Awareness program, a school-based suicide prevention program. In comparing pre- and post-test responses, the majority of students reported the awareness program significantly reduced feelings of sadness and hopelessness. In addition, the students contemplated suicide less than when they became part of the Surviving the Teens Suicide Prevention and Depression Awareness program in comparison to when they were not in the program. This study exemplifies that if the issue is addressed, such issues as the depressive symptoms can be addressed, and treatment can potentially reduce symptoms that can negatively affect the individual's current and future well-being.

Depression and depressive symptoms are more dominant among females than males (Pratt & Brody, 2014; World Health Organization, 2017). According to Ko, Farr, Dietz, and Robbins (2012), one out of every ten women in the United States experience symptoms of depression. Women are about twice as likely as men to be diagnosed with depression (Danielsson, Bengs, Lehti, Hammarström, & Johansson, 2009; Martin, Neighbors, & Griffith, 2013). Previous research suggests that women have a higher prevalence of lifetime major depression than men (Baxter et al., 2014; Ford & Erlinger, 2004; Kelly, Tyrka, Price, & Carpenter, 2008; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). Women are also more likely to develop major depression than men (Cvjetkovic-Bosnjak, Soldatovic-Stajic, Babovic, & Sakac, 2016). Additionally, Pratt and Brody (2014) found that females experienced depression and depressive symptoms more than males, among adults ranging in age from 40 to 59.

Researchers who have examined immigrants and depressive symptoms have found a relationship between acculturative stress and depression (Rhee, 2009; Tummala-Narra, Alegria, & Chen, 2012) or depressive symptoms (Oh et al., 2002; Rhee, 2016). Thus, it is helpful to understand the issues that immigrants face and the process of acculturation.

### Immigrants

Immigration is a stressful experience for people of any age (Ayers et al., 2009; Benish-Weisman, 2009; Berry, 1997, 2001, 2005; Berry, Kim, Minde, & Mok, 1987; Choi, 1997; Choi, et al., 2009; Kim et al., 2005; Kuo & Tsai, 1986; Nah, 1993; Padilla, Cervantes, Maldonado, & Garcia, 1988; Park & Rubin, 2012; Park & Bernstein, 2008; Park et al., 2013; Sabatier & Berry, 2008; Shin et al., 2007; Sin et al., 2011). Immigrants can experience stress related to cultural changes, ethnic discrimination (Cano et al., 2015), changes in social support, and changes in parent and child relationships (Levitt, Lane, & Levitt, 2005). Stress can occur at any period during the immigrant journey, including before immigration, during the immigration, and after immigration (Dow, 2011; Schwarzer & Luszczynska, 2003; Yakushko et al., 2008). An overview of the following studies demonstrates the diverse characteristics of stress related to immigration.

Cano et al. (2015) studied the longitudinal effects of cultural stress on depressive symptoms and a range of unproductive behaviors that included cigarette smoking, alcohol use, aggression, and rule breaking among Hispanic adolescents who immigrated to the U.S. within the previous five years. Three hundred and two Hispanic immigrant adolescents, with a mean age of 14.51 years, with 141 girls and 161 boys, participated in this study. The participants completed measurements of perceived ethnic discrimination, bicultural stress, and perceived negative context of reception. Additionally, this study evaluated participants' depressive symptoms, cigarette smoking, alcohol use, aggressive behavior, and rule-breaking behavior during a six-month period. Findings suggested that higher cultural stress predicted increased odds of smoking ( $OR = 1.24, p < .001$ ), odds of binge drinking ( $OR = 1.2, p < .001$ ), levels of aggressive behavior ( $\beta = .28, p < .001$ ), levels of rule-breaking ( $\beta = .25, p < .001$ ), and levels of depressive symptoms ( $\beta = .38, p < .01$ ) among the Hispanic immigrant adolescents.

Levitt et al. (2005) studied generational variations in the stresses related to immigration and the child and parent psychological adjustment as related to stress and social support. The authors' study examined the comparability of immigration experiences among recent immigrant children, ranging in age from 7 to 18 years, and their parents who immigrated from Argentina, Colombia, Cuba, Haiti, and the English-speaking West Indies. The researchers found that the data indicated both children and parents experienced a number of stressors since they immigrated to the U.S. Findings suggested that children generally reported more immigration stress than did parents ( $F(1,424) = 32.40, p < .0001$ ), although parents were more likely to have economic worries. The researchers found that stress levels varied for immigrants by their nation of origin, with Haitian immigrants reporting the highest levels of stress. Argentinean and Colombian immigrant parents reported less stress than did parents from other nations. According to Levitt et al. (2005), the stresses related to immigration were influenced by and associated with psychological adjustment for both parents and children. Children evidenced greater depression, more symptoms, lower self-concept, and poorer school adaptation under high stress conditions. Parents reported stress had significantly diminished their affect and life satisfaction. Parents with lower support experienced more stress ( $m = 8.20, sd = 4.44$ ), compared to parents with higher support ( $m = 6.78, sd = 3.78$ ),  $F(1, 427) = 12.70, p < .0001$ . Because the findings concerning immigration stress were across participants from the varying nations of origin, but stress levels varied by nation or origin, it is important to examine immigration stress, or acculturation stress, by nation or origin and not for all immigrants, regardless of national origin.

Park et al., (2014) studied acculturation and acculturative stress as predictors of alcohol use among subgroups of Asian immigrants. This study used secondary analysis of data from the National Latino and Asian Americans Survey (NLAAS), which collected information between May 2002 and December 2003 from a nationally representative sample of noninstitutionalized

Asian immigrants who were 18 years of age or older and resided in the United States. The researchers analyzed data from the Chinese ( $n = 600$ ), Filipino ( $n = 508$ ), and Vietnamese ( $n = 520$ ) immigrants who were born outside of the U.S. The researchers found that alcohol variation among the immigrants by national origin was statistically significant ( $F = 29.4, p < .001$ ) and that among all ethnicities, more than half of the immigrants reported experiencing everyday discrimination and general acculturative stress. Over half of the Chinese and Filipino participants also reported experiencing family cultural conflict. Significant differences among the Asian ethnicities existed for experiences of everyday discrimination ( $\chi^2 = 29.32, p < .001$ ), general acculturative stress ( $\chi^2 = 19.66, p < .001$ ), and family cultural conflict ( $\chi^2 = 7.70, p < .01$ ). Results of this study indicate that within the Asian population, experiences of everyday discrimination, acculturative stress, and family cultural conflict are common, but subgroups experience these occurrences at different rates.

Leaving a home country and having to acclimate to a foreign country can be an arduous journey. Moving to a new country can be difficult and a stressful process for people, whether they immigrate voluntarily or involuntarily. Li (2016) conducted a study examining whether pre-migration trauma including physical/sexual assault, combat/war, natural/man-made disasters, or crime victimization exposure is associated with post-migration acculturative stressors. These stressors include guilt of leaving family and friends, social isolation, communication difficulty, employment difficulty, legal status stress, and race- and language-based discrimination. Li (2016) found about half of all Asian and Latino immigrants have experienced at least one form of pre-migration trauma before arriving in the U.S. Findings suggest that Asian immigrants with pre-migration trauma are more likely to report feeling guilty for leaving family/friends behind, social isolation, communication difficulty, employment difficulty, legal status stress, race-based discrimination, and language-based discrimination. In comparison with Asian immigrants, Latino

immigrants with pre-migration trauma were more likely to report all forms of acculturative stressors except employment difficulty. Both the Asian and Latino immigrants with pre-migration trauma were more likely to experience traumatic events after migrating to the U.S. than immigrants who were not exposed to pre-migration trauma (56% vs. 30% for Asian immigrants,  $p < 0.001$ ; 56% vs. 40% for Latino immigrants,  $p < 0.001$ ). Results indicated that pre-migration trauma exposure is positively associated with social isolation (43% vs. 33% for Asian immigrants,  $p < 0.001$ ; 56% vs. 40% for Latino immigrants,  $p < 0.001$ ), communications difficulties (43% vs. 26% for Asian immigrants,  $p < 0.001$ ; 51% vs. 40% for Latino immigrants,  $p < 0.001$ ), legal status stress (22% vs. 15% for Asian immigrants,  $p < 0.001$ ; 44% vs. 33% for Latino immigrants,  $p < 0.001$ ), and race-based discrimination (29% vs. 20% for Asian immigrants,  $p < 0.001$ ; 32% vs. 27% for Latino immigrants,  $p < 0.001$ ).

Pre-migration is not the only challenge affecting the immigration process. Immigration is a life transition that can affect the psychological and physiological health of immigrants (American Psychological Association, Presidential Task Force on Immigration, 2012; Berry, 1997, 2001, 2005). Many people may think that immigration is a positive transition that helps or improves a person's life. However, immigration may include pain and loss that people as they lose or weaken family ties, friendships, jobs, and social resources (American Psychological Association, Presidential Task Force on Immigration, 2012; Berry, 1997, 2001, 2005). Immigrants not only physically leave their place of origin, but they also leave their place of socialization and often an environment that supports their traditional values and ways of thinking (Lin & Ensel, 1999; Nah, 1993; Shen & Takeuchi, 2001; Sonderegger & Barrett, 2004). Feberga (as cited in Short & Johnston, 1997) stated that immigrants experience stress related to the loss of loved ones or family and familiar surroundings. Settling down within the new society adds to

this stress (Lee, 2010; Rhee, 2009). Settling down in a new country may be associated with other unavoidable social and material losses.

Immigration demands significant amounts of adjustment to the new life in a foreign country (Berry, 1997, 2001, 2005; Choi, 1997; Coll & Magmuson, 1997; Laosa, 1997). Berry (1997) stated that immigrants face various physical, psychological, social, and cultural changes while adapting to a new society. Many scholars have studied the psychological impact of individuals who move to a new country for several decades (e.g., Berry, 1997; Geeraert & Demoulin, 2013; Graves, 1967; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). According to Berry (2001), without social support and while losing one's ties to the individual's origin, many immigrants encounter a number of difficulties and various psychological distresses. Recently arrived immigrants also encounter a number of stressors and risks, including different climate, language barriers (Nandan, 2005; Yakhnich, 2008), missing family members (Bernier, 1992; Eisenbruch, 1991), unfamiliar customs, ethnic identification, different culture, new norms, insecure jobs (Edelstein, 2005; Yakhnich, 2008), poverty, discrimination (Liebkind & Jasinskaja-Lahti, 2000), and social isolation (Finch et al., 2003; Hiott et al., 2008; Kiang et al., 2010). Therefore, it is imperative for mental health professionals to understand the potential psychological stressors that immigrants face when they transition to living in a new country.

### **Immigrants as Individuals**

Perreira and Ornelas (2011) stated that many immigrants (both adults and children) are stressed by new changes in short periods of time, such as needing to learn a new language, changes in family roles and responsibilities, and encountering racism or discrimination (Karlsen, 2002; Morgan, Charalambides, Hutchinson, Murray, 2010; Veling, Selten, Mackenbach, & Hoek, 2007). However, settling down in the United States may be more difficult for adult immigrants than for their children. According to Yoon, Lee, Koo, and Yoo (2010), adult immigrants face

more challenges including, “responsibility for family survival, loss of previous social status, change in gender roles and marital relationships, and greater difficulties with language/cultural learning than younger immigrants” (p. 524).

Adult immigrants are placed in a difficult situation related to the new language and adapting to a new culture. It is harder and takes longer for adults to adjust and to adapt to new changes, including language and culture, than it is for children (American Psychological Association, Presidential Task Force on Immigration, 2012; Jang, Kim, Chiriboga, & King-Kallimanis, 2007; Miller, Wang, Szalacha, & Sorokin, 2009). Generally, adult immigrants, including parents, are likely to maintain their own native culture more so than their children, and adopt the host culture less than their immigrant children or U.S.-born children (Chuang & Tamis-LeMonda, 2013; Park, 2015; Ying & Tracy, 2004). Most adult immigrants also report that they experience a lack of interaction and communication at hospitals, courts, and schools because of language barriers (Yoo & Vonk, 2012). For example, most adult immigrants experience the greatest difficulty obtaining a new language and reducing the language barrier. Takahashi (as cited in Mori, 2000) stated that to acquire foreign language proficiency, especially in adult years, requires long periods of intense study, strong linguistic ability, and a large knowledge of the new culture.

Harris-Reid (as cited in Yoo & Vonk, 2012) stated that adult immigrants from non-European countries have experienced more acculturative stress in the process of obtaining new cultures and languages than European immigrants. According to Harris-Reid (as cited in Yoo & Vonk, 2012), non-European immigrants have more experiences of prejudice and discrimination than European immigrants. Individuals who are racially distinct from the majority experience more discrimination than people who are more similar to the majority (Berry & Sabatier, 2010; Liebkind & Jasinskaja-Lahti, 2000). Brown et al. (2000) stated that many foreign-born



individuals from non-European countries, such as Asia, Latin America, the Caribbean, and Africa, confront racial discrimination for the first time in the United States.

American Psychological Association, Presidential Task Force on Immigration (2012) stated that immigrants can be recognized by their accents when they speak English, their unfamiliar names, and their differing manners and styles of dress. For example, Yip, Gee, and Takeuchi (2008), reported that Asian immigrants experienced more discrimination than Asian Americans who were born in the United States. According to Taylor (2013), 74% of adult immigrants from Asian countries were born abroad, and 50% of Asian immigrants reported that they do not speak English. Because of this language barrier, it is important that research be conducted in Asian immigrants' native languages.

### **Immigrants as Families**

Immigrant families are challenged with many adversities while merging into and adapting to western culture in the United States. According to Foner (1997), immigrant families are often faced with new family arrangements, roles, and orientations, that are expected or necessary due to the structural restrictions and conditions in the new environment. Researchers indicated that the immigrant families experience culture shock, adjustment stress, and sociocultural disruption in the U.S. (Chu & Montgomery County Public Schools, 1993; Chuang & Tamis-LeMonda, 2013; Hurh, 1998; Kim & Miura, 1999; Park, 2015) while restructuring and redefining family life.

Frequently, immigrant families move to the United States with their children, and conflicts between parents and children arise (Chuang & Tamis-LeMonda, 2013; Nah, 1993; Park, 2015). Conflicts often occur between parents, who immigrated to the United States as adults, and their children, who are either U.S.-born or immigrated at a young age (Nah, 1993). Nah (1993) stated that children who are either U.S. born or immigrated at a young age quickly engage and

acquire the new culture and language, while their parents, from foreign nations, struggle to adopt and adjust to the new culture and language (Lee, Choe, Kim, & Ngo, 2000). Asian immigrant families may live in two different cultures that are inharmonious with cultural values and norms in the United States (Hwang, 2006; Park, 2015). Asian immigrant parents have interacted in their country of origin throughout their childhood and early adulthood and want to keep their own ethnic identity (Kim, Gonzales, Stroh, & Wang, 2006). This cultural conflict between the parents and children can add to the acculturative stress that immigrants experience.

According to Dinh and Nguyen (2006), immigrant parents experience frustration, anxiety, distress, and stress of acculturation that can lead the parents to encounter psychological difficulties such as depression. Lee et al. (2000) stated that immigrant parents show that they are more likely than their children to maintain their own native language, culture, values, and traditional customs instead of transitioning into mainstream society. Asian parents emphasize Asian orientation to their children, known as collectivism. Collectivism is described as unconditional obedience, respect to authority, and duty or obligation to another (Chao, 1994; Chao & Tseng, 2002; Espiritu, 2003; Markus, 2008; Markus, Mullally, & Kitayama, 1997; Rudy & Grusec, 2006). Many Asian immigrant parents employ an authoritarian, restrictive parental style that characterizes strict rules and less expression of affection; while European American parents more typically endorse a firm and warm parental style (Chao, 1994; Chao & Tseng, 2002). Berry (1997) stated that Asian families traditionally prefer to be culturally collectivistic, which highlights interdependence, conformity, emotional self-control, and humility. The traditional Asian culture strongly values obligation and orientation to the family, including respect for and obedience to parents and elders (Chao & Tseng, 2002). Consequently, intergenerational gaps arise between Asian immigrant parents and their children (Lee & Landreth, 2003; Park, 2015). Because of the different stages of acculturation and gaps of acculturation, the

immigrant parents, especially Asian, face various difficulties in their relationships with their children (Park, 2015). Thus, differences exist between children and parents from immigrant families, and, as a result, mental health issues can arise that put the families in a risky position (Kim et al., 2006; Park, 2015).

The families may struggle to converge their traditional values and new systems (Hurh, 1998). One of the biggest challenges for the immigrant families is that immigration demands redefinition and reconstruction of family members' roles (Min, 2001). Immigrant families often experience role changes that involve gender, and generational relationships (Kibria, 1993; Min, 1988; Thomas, 1995; Tummala-Narra, 2004). According to Mahdi (1999), changes in the family and gender roles are the most challenging to immigrants because these changes involve "not only changes in the identity and behavior of individual immigrants but also in relationships with their intimates" (p. 51). While managing difficulties of a settlement, such as language barriers and cultural adjustments in the U.S., the gender roles of immigrant family members shift, and the changing roles can increase stress within the families (Kibria, 1993; Min, 1988; Park, 2015; Thomas, 1995; Tummala-Narra, 2004).

Switching the families' gender roles can restructure family dynamics and distress an individual's adjustment (Min, 2001; Park, 2015). Immigrant women especially may experience serious psychological risks in changes to new gender roles (Lee, 2007; Lim, 1997; Mahdi, 1999; Min, 2001; Park, 2015; Shirpak, Maticka-Tyndale, & Chinichian, 2011; Yakushko & Chronister, 2005). According to Min (2001), one of the major changes among immigrant families is "increased participation of immigrant women in the labor force" (p.302) and economic activity. Economic difficulties may push immigrant women to work outside of the home (Kibria, 1993; Lim, 1997; Min, 1988, 2001). Commonly, immigrant women need jobs to survive in the new environment due to the long-term financial needs generated by their husbands' or fathers'

inadequate earnings (Lim, 1997; Pedraza, 1991). Immigrant women occasionally take the role of head of household due to the loss of male a figure's support through illness, death, or abandonment (Pedraza, 1991).

The participation of married or unmarried immigrant women in economic activity and the labor market increases marital and family conflicts (Booth, Johnson, White, & Edwards, 1984; Lim, 1997; Min, 1998, 2001; Park, 2015; Spitze, 1988; Spitze & South, 1985). Even though immigrant women work longer hours and greatly contribute to increasing their families' income, the partition of housework and gender expectations conflict with the traditional gender roles (Lee, 2007; Lim, 1997; Min, 2001; Shirpak et al., 2011; Yakushko & Chronister, 2005). According to Kluwer, Heesink, and Van de Vliert (1996), the division of house labor is one of the major sources of the marital conflict of immigrant couples. Many immigrant males, especially husbands, demand to continue traditional sex roles and attitudes that include patriarchal authority (Lim, 1997; Min, 2001; Negy & Snyder, 1997, 2000). This increases immigrant women's marital and family conflicts and psychological instability (Lee, 2007; Min, 1998, 2001; Negy & Snyder, 1997, 2000; Park, 2015; Shirpak et al., 2011; Yakushko & Chronister, 2005). Additionally, immigrant women's role reversal requires a redefinition of immigrant men's roles within their families (Mahdi, 1999; Min, 2001; Negy & Snyder, 1997, 2000). Immigrant males experience a crisis because they experience their traditional identity as being rejected by the redefinition of gender role after immigration (Mahdi, 1999; Min, 2001). Immigrant husbands also experience their provider role and social status as meaningfully damaged following immigration (Min, 2001).

### **Acculturation**

Acculturation is a term generally referring to a process of adapting to a new culture (Ayers et al., 2009; Berry, 2004; Berry, 2005; Berry, 2012; Choi et al., 2009; Hwang & Ting,

2008; Kim et al., 2001; Lee et al., 2004; Park & Bernstein, 2008; Redfield, Linton, & Herskovits, 1936; Rogler et al., 1991; Rudmin, 2006, 2009; Schiro, 2012; Shen & Takeuchi, 2001; Torres, 2010). When ethnic groups continually and directly have contact with a different culture, cultural and psychological changes essentially occur (Berry, 1997; 2001; 2005; 2006). Previous studies on acculturation of immigrants found that acculturation is a universal human experience (Rudmin, 2006) and every immigrant goes through the acculturation after they immigrate to any country (American Psychological Association, Presidential Task Force on Immigration, 2012; Berry, 1997, 2001, 2005).

The earliest definition of acculturation was given by anthropologists Robert Redfield and his colleagues. Redfield, Linton, and Herskovits (1936) stated “acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups” (p. 149). Many researchers have cited this definition since it was identified (Berry, 1997, 2001, 2005; Choi et al., 2009; Hwang, 2006; Hwang & Ting, 2008; Kang, 2006; Lueck & Wilson, 2010; Miller, Kim, & Benet-Martínez, 2011; Rudmin, 2009; Salant & Lauderdale, 2003; Torres, 2010; Ward 2006; Yoon, Langrehr, & Ong, 2011), but it focused more on cultural alteration and comprehensive aspect of acculturation (Berry, 2005). Graves (1967) later presented the aspect of psychological acculturation that refers to changes in behaviors and values of individuals experiencing psychosocial adjustments and adaptations while participating in the new culture. Thus, acculturation is a change in the psychology of the individual (Berry, 1997).

Berry (2005) identified that acculturation is “the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (p.698). Acculturation is a process of modification for people who come from another culture; their behaviors and attitudes are socialized into that of the majority

cultural group (Rogler et al., 1991). According to Shen and Takeuchi (2001), acculturation is positively correlated to immigrants' mental health status (Devolder et al., 2013). Thus, acculturation is closely and strongly associated with immigrants' psychological states.

Acculturation is "a multidimensional process that involves changes in many aspects of immigrants' lives" (American Psychological Association, Presidential Task Force on Immigration, 2012, p.26). The acculturation process involves various factors, including language, social status, social relationships and network systems, identity, values, and attitude (Lee et al., 2004; Park & Bernstein, 2008). Chia and Costigan (2006) stated that immigrants' external domains which include behavioral features, such as the use of language, could change faster than their internal domains, which include psychological features, such as the values, even though immigrants present with the individual's own cultural orientation and, values.

Through previous studies, researchers have found that acculturation is a stressful period and an important factor for immigrants' adjustment (Ayers et al., 2009; Berry, 2005; Berry & Kim, 1988; Choi et al., 2009; Hwang & Ting, 2008; Kim et al., 2001; Lee et al., 2004; Park & Bernstein, 2008; Rogler et al, 1991; Rudmin, 2009; Shen & Takeuchi, 2001; Torres, 2010). For example, immigrants normally can experience serious and effective stress while adopting a new language, customs, and social norms (Choi et al., 2009). Ryder, Alden, and Paulhus (2000) also stressed that acculturation is accompanied by severe stress that requires cognitively and emotionally adopting and retaining new attitudes, new values, or new behaviors that reflect a new culture. Therefore, many immigrants experience serious psychological stress, which can take the form of depression, anxiety disorders, somatic complaints, and perceived powerlessness (Min & Lubben, 2005). In addition, psychological impacts on acculturation could be greater on adult immigrants, including parents, than on their children, who migrated in childhood or who were born in the U.S. (Min & Lubben, 2005).

### **Acculturative Stress**

Individual immigrants have varied ways of managing acculturative adjustment and different acculturation experiences (Choi et al., 2009). For instance, immigrants can experience high amounts of acculturative stress while going through the process of acculturation (Ayers et al., 2009; Berry, 1997, 2005; Choi, 1997; Choi et al., 2009; Constantine, Okazaki, & Utsey, 2004; Crockett et al., 2007; DeVylder et al., 2013; Hwang & Ting, 2008; Kuo, 1984; Kim, Atkinson, & Umemoto, 2001; Lee et al. 2004; Lueck & Wilson, 2010; Park & Bernstein, 2008; Park & Rubin, 2012; Rogler et al., 1991; Rudmin, 2009; Salant & Lauderdale, 2003; Shen & Takeuchi, 2001; Turner & Avison, 2003; Torres, 2010; Ward, 2006). Acculturative stress is what immigrants may experience during the process of acculturation, which is when they attempt to solve their problems and conflicts of adjustment and integrate into a new culture (Berry & Kim, 1988). It simply defines the unique stressors of immigration (Berry, 1970, 1997, 2001, 2005, 2006).

The concept of acculturative stress was introduced by Berry (1970), who emphasized the impact of migration on individual psychology. According to Berry (1997), acculturative stress is “a stress reaction in response to life events that are rooted in the experience of acculturation” (p. 19). Acculturative stress is defined as (a) containing pressure, tension, and stress during the acculturation period, and (b) potentially increasing dangerous effects on the immigrants’ physical and mental health (American Psychological Association, Presidential Task Force on Immigration, 2012; Berry 1997; Rudmin, 2009). A variety of stressors associated with acculturative stress include differences in climate, language barriers (Nandan, 2005; Yakhnich, 2008), missing family members (Bernier, 1992; Eisenbruch, 1991), unfamiliar customs, ethnic identification, different culture, new norms, insecure job (Edelstein, 2005; Yakhnich, 2008), poverty, discrimination (Liebkind & Jasinskaja-Lahti, 2000), social isolation (Finch et al., 2003; Hiott et

al., 2008; Kiang et al., 2010), marital conflicts (Ben-David & Lavee, 1994; Chuang & Tamis-LeMonda, 2013; Kibria, 1993; Min, 1988, 2001), and family and generation gap conflicts (Chuang & Tamis-LeMonda, 2013).

Researchers have examined the significant connection of acculturative stress and psychological distress and have found positive relationships between acculturative stress and mental health distress (Ayers et al., 2009; Chio, 1997; Choi et al., 2009; Crockett et al., 2007; Han, Kim, Lee, Pistulka, & Kim, 2007; Hovey, 2000; Huang, Wong, Ronzio, & Yu, 2007; Hwang & Ting, 2008; Oh, Koeske, & Sales, 2002; Shin et al., 2007). For example, Revollo, Qureshi, Collazos, Valero, and Casas (2011) conducted a study examining acculturative stress as a risk factor for depressive and anxiety disorders as well as their symptomatology. A total of 414 Latin American immigrants who used public primary care centers in the metropolitan area of Barcelona, Spain, participated in interview session before or after a routine visit with their healthcare providers. Revollo et al. (2011) used the Barcelona Immigration Stress Scale (BISS) to measure acculturative stress and the Spanish version of Goldberg Anxiety and Depression Scale (GADS) to assess depression and anxiety in this study. Additionally, Revollo et al. (2011) used the Spanish version of the Mini International Neuropsychiatric Interview (MINI), which is a semi-structured interview. The MINI was designed to measure depressive and anxiety disorders including major depressive disorder, dysthymia, panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder. The data indicated that acculturative stress is associated with depression and anxiety and constitutes a risk factor for both depression and anxiety. According to Revollo et al. (2011), general psychosocial stress, related to difficulties that immigrants may confront in a new country, was highly associated with both depression and anxiety, and intercultural contact stress was also



related to depression. Findings suggest that cultural harmony plays a key role in the relationship between immigration and mental health.

In another example, Jang and Chiriboga (2010) conducted a study to determine the relationship among acculturation, acculturative stress, and mental distress in Korean American elders. A total of 472 Korean American elders who were age 60 or older, had sufficient cognitive ability to understand and complete the survey, and were residents of Florida participated in the study. The participants completed a 12-item inventory to measure their levels of acculturation. This inventory contained two items for each of the following six domains: language, media consumption, food consumption, social relations, sense of belonging, and familiarity with the culture. Eight items that were selected from the Acculturative Stress Scale (ASC) were used to measure acculturative stress. The items from the ASC represented by two domains, task-oriented stress and emotion-oriented stress. A 15-item short form of the Geriatric Depression Scale (GDS-SF) was used to assess depressive symptoms and three items from the Aging, Status, and the Sense of Control (ASOC) study were used to measure anxiety. Findings indicated that the level of acculturation was significantly related to mental health. The study also found that acculturative stress functions as a mediator in the relationship between the level of acculturation and mental distress. The researchers suggested that positive adaptation and promotion of mental well-being could benefit Korean immigrant elders.

Similarly, Rhee (2016) conducted a study examining the relationships of personal factors, acculturative stress, and depressive symptoms among Korean immigrant elders. One hundred and eight first-generation Korean immigrants who were cognitively and physically healthy participated and completed a structures survey in the research. The participants lived in an area without Korean ethnic enclaves, and they were 60 years and above age in age. The researcher used the Geriatric Depression Scale-Short Form (GDS-SF) to measure depressive symptoms, the

Suinn-Lew Asian Self-Identity Acculturation scale (SL- ASIA) to measure the level of acculturation, the Acculturative Stress Index (ASI) to measure acculturative stress and the Life Events Questionnaire (LEQ) to measure stressful life events. This study indicated that personal factors such as levels of acculturation and socioeconomic status might influence acculturative stress and depressive symptoms negatively. However, acculturative stress was identified as the most significant risk factor for depressive symptoms.

As a mental health provider, it is important to understand what acculturative stress is, what the impact of acculturative stress is on immigrants' mental health, and how immigrants cope with acculturative stress while adjusting to the new culture. Additionally, it is strongly recommended to mental health providers who work with multicultural clients that they be aware of adjustment patterns and associated challenges that affect immigrants' quality of life. Culturally relevant coping methods can be recommended to immigrants to prevent mental health deterioration while adjusting to a new culture (Kuo, 2011, 2014).

### **Conceptualization of Coping**

The most popular definition of coping was greatly influenced by the transactional theory of stress and coping (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) defined coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). Lazarus and Folkman (1984) viewed coping as a process-oriented approach that focuses on “what the person actually thinks or does” (p. 142) in a specific stressful encounter and “change in coping thoughts and acts as a stressful encounter unfolds” (p. 141). Lazarus and Folkman (1984) also emphasized transactions between an individual and the environment, and an individual's capability of managing a stressful encounter. This meaning of coping suggests it is important to know how a person evaluates stressful events or environments and how the person can manage a

stressful environment. Lazarus and Folkman (1984) simply defined coping as an individual's "efforts to manage" (p. 178) particular situations or environments.

### **Major Functions of Coping**

Lazarus and Folkman (1984) proposed two forms of coping with stressors: *problem-focused coping* and *emotion-focused coping*. Problem-focused coping functions to manage or alter the problems with the environment that cause stress (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984, 1987). According to Lazarus (1993), problem-focused coping functions so that "if a relationship with the environment is changed by coping actions the conditions of psychological stress may also be changed for the better" (p.8). The emotion-focused coping regulates the emotional reaction to the problem (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984, 1987). Lazarus (1993) defined emotion-focused coping as changing "only the way we attend to or interpret what is happening" (p. 8).

According to Lazarus and Folkman (1984), the problem-focused form of coping is directly changing the source of stress and the emotion-focused form of coping is managing an individual's emotional reaction to the stressor. The problem-focused form of coping generally occurs when an individual knows how to manage the problem to get a positive outcome and he or she knows how to control it over a particular situation without letting the individual's emotion get in the way (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984, 1987). For example, a student prepares a study schedule in advance for a final test versus complaining to other students about the test.

The emotion-focused form of coping occurs when an individual realizes that he or she has little control over a situation and is not be able to find the source of the problem (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984). The emotion-focused form of coping relates to internal elements that are needed to deal with negative emotional states such as anxiety,

depression, fear, or frustration (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984). When the stressful situation or event is outside an individual's control, the emotional-focused form of coping helps with the stress (Folkman & Lazarus, 1980; Lazarus, 2006; Lazarus & Folkman, 1984, 1987). Lazarus and Folkman (1984) suggested that individuals use the emotion-focused form of coping "to maintain hope and optimism, to deny both fact and implication, to refuse to acknowledge the worst, and to act as if what happened did not matter" (p. 151). For example, when a child is diagnosed with a terminal illness, the mother might manage her stress to change her perspective or appraisal of the stress instead of changing the child's diagnosis. Another example is that a child who seeks social support might choose to stay away from his or her school because of a bully. Lazarus and Folkman (1984) stated that both problem-focused and emotion-focused forms of coping affect each other during a stressful situation and "facilitate and impede each other" (p. 179).

Lazarus (1966) stated that there are two processes that mediate between a person and an environmental relationship. These processes are appraisal and coping. Folkman and Lazarus (1980) identified *appraisal* as "the cognitive process through which an event is evaluated with respect to what is at stake and what coping resources and options are available" (p. 223). Lazarus and Folkman (1984) presented cognitive appraisal as a "process of categorizing an encounter, and its various facets, with respect to its significance for well-being" (p. 31). This involves not only information processing, but also is largely and cognitively evaluated as potential stress (Lazarus, 1966, 1993, 2000, 2006; Lazarus & Folkman, 1984, 1987). There are two cognitive appraisals, primary and secondary appraisals (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984, 1987).

The primary appraisal is a judgment to determine "whether anything is at stake" (Lazarus, 2006, p. 76). The primary appraisal process involves a person evaluating whether any potential

stimulus, including events and situations, pose a threat to the individual (Lazarus, 2000; Lazarus & Folkman, 1984, 1987). There are three types of primary appraisals: irrelevant, benign-positive, and stressful (Lazarus & Folkman, 1984, 1987). An irrelevant appraisal is when an individual determines that a situation has “no implication for a person’s well-being” (Lazarus & Folkman, 1984, p. 32) and is ignored. A benign-positive appraisal is when an encounter is considered as positive or beneficial (Lazarus & Folkman, 1984, 1987). Lastly, a stressful appraisal is when events are regarded as harmful, threatening, or challenging to a person’s well-being (Lazarus & Folkman, 1984, 1987). According to Lazarus and Folkman (1984, 1987), harm, or loss, refers to some damage or danger that has already happened to the person. Threat is harm or loss that has “not yet taken place but are anticipated” (Lazarus & Folkman, 1984, p. 32). Challenge is potential gain or growth from feelings of confidence from demands.

The secondary appraisal indicates a “cognitive-evaluative process” (Lazarus, 2006, p. 76), which focuses on anything that “can be done as well as on what is at stake” (Lazarus & Folkman, 1984, p. 35). The secondary appraisal process involves how a person deals with a primary appraisal of harm, threat, or a challenging situation (Lazarus, 2000; Lazarus & Folkman, 1984, 1987). This appraisal refers to an individual’s available coping options for working with demands (Lazarus & Folkman, 1984, p.35). An individual essentially evaluates the possible coping strategies, such as “his or her competence, social support, and material or other resources” (Schwarzer & Luszczynska, 2012, p. 31) that can help to alter the perceived harm, threat, or challenge and to recreate a “more positive environment” (Perrewé & Zellars, 1999, p. 740).

### **Effects of Coping**

Folkman and Lazarus (1980) refer to *coping* as “the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them” (p.

223). When an individual is faced with a stressful situation, he or she will evaluate what the stressor is and look for potential personal relevant resources and options (Ntoumanis, Edmunds, & Duda, 2009). Folkman and Lazarus (1980) refer to this as a *coping process* (p. 224), which is what an individual “actually thinks and does in a particular encounter and to change in these efforts as the encounter unfolds during a single episode or across episodes” (p. 224).

Various stress appraisals can lead to different coping reactions and responses. However, it is important to build an effective coping strategy to provide better quality of life and physiological health. According to Lazarus and Folkman (1984), effective coping involves appropriate situational appraisal and selection of coping reactions. The successful coping strategies will lead to positive outcomes on an individual’s social functioning, interpersonal relationships, psychological well-being, and somatic health issues (Lazarus & Folkman, 1984). A large number of studies have been conducted to examine and measure coping strategies (Frydenberg, 2014).

For example, Puhl and Luedicke (2012) conducted a study to examine how adolescents react to and cope with experiences of weight-based victimization at school. Two-hundred-and-twenty-one female and 173 male high school students in central Connecticut participated the study. The mean age was 16.4 years. A total of 394 adolescents completed six self-report measurements that were used to evaluate the adolescents’ experiences of weight-based teasing and bullying at school, affective responses to these experiences, and coping strategies used to deal with incidents of weight-based victimization. This study indicated all participating students reported that they experienced weight-based victimization. About half of the students reported that they felt sad, depressed, worse about themselves, bad about their body, angry, and afraid, while the other half reported not bothered or about the same. Both male and female students with negative affect in response to weight-based victimization reported that they used avoidance

and maladaptive coping strategies, such as avoiding physical activity, increased food consumption, or binge eating. The findings highlight the need for support in helping individuals identify and implement more adaptive coping strategies, including seeking social support in response to victimization to prevent unhealthy behaviors.

Another example is a study conducted by Meade and colleagues (2010) that examined the effects on chemical dependency of a coping group intervention for HIV-positive adults with childhood sexual abuse (CSA) histories. Two-hundred-and-forty-seven participants, who were HIV-positive men and women with childhood sexual abuse (CSA) histories, were recruited from AIDS service organizations and community health centers in New York City between March 2002 and January 2004. Participants were randomly assigned to the experimental coping group or a time-matched comparison support group. A group coping intervention was Living in the Face of Trauma (LIFT) which focuses on the unique needs of HIV-positive persons with CSA histories. The experimental coping condition (LIFT) was based on the integrated cognitive theory of stress and coping and effective cognitive-behavioral treatment strategies for sexual trauma. This LIFT group intervention focused on identifying current stressors correlated with HIV and CSA and developing adaptive coping strategies. Chemical dependency use was evaluated pre- and post-intervention and every 4 months during a 1-year follow-up period. Findings suggest that LIFT was significantly greater in reducing alcohol for participants in the experimental coping group than those in the support groups. Using a coping strategy, participants in the experimental coping group learned how to identify specific stressors related to HIV and CSA. The participants developed problem-focused (i.e., effective communication, problem solving) and emotion-focused (i.e., cognitive restructuring) strategies. The experimental group also focused on developing skills, including coping more effectively with stressors (Meade et al., 2010).

According to Lazarus and Folkman (1984), coping is “constantly changing cognitive and behavioral effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). Individuals would determine how to cope and manage with the stressors when faced with stress or a stressful situation (Folkman & Moskowitz, 2004). An individual’s ability to cope in a particular situation depends on the availability of resources to the individual (Lazarus & Folkman, 1984). Coping may lead to positive or negative outcomes depending on the resource and strategies available (Folkman & Moskowitz, 2004).

### **Culture and Coping**

Coping strategies and behaviors are strongly associated with a person’s cultural norms or the more general societal norm (Lam & Zane, 2004; Lazarus & Folkman, 1984). An individual who needs to develop coping strategies should be able to develop coping strategies that are consistent with his or her culture (Lam & Zane, 2004; Lazarus & Folkman, 1984). Chun, Moos, and Cronkite (2006) stated that a person’s coping strategies are influenced by cultural values and beliefs; however, many studies of stress and coping theories largely focus on the western cultural perspective, which is an individualistic approach that may not be appropriate for people from eastern or collectivist cultures (Kuo, 2011; Chun et al., 2006). According to Kuo (2011), the individualistic cultures emphasize the individual’s value or right, so the individual has the ability to control or change his or her environment to fit the individual’s personal needs. However, collectivistic cultures focus on interdependence and an individual's desire to maintain harmony with a given group (Shulruf, Hattie, & Dixon, 2007). Asian Americans are widely defined by a collectivistic cultural perspective and expect to use more cognitive and avoidance-focused coping strategies that call for change in an individual’s thoughts, emotions, and behaviors (Chun et al., 2006).



## **Counseling**

Counseling is “a professional relationship [that] empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.” (Kaplan, Taryydas, & Gladding, 2004, p. 366). For immigrants, seeking help from a mental health practitioner can be a last solution or method. To provide effective mental health services to immigrants, mental health practitioners must understand immigrants’ needs and be aware of diverse cultures to help immigrants adjust to their new lives.

### **Korean Attitudes Towards Counseling**

To investigate the expectations of counseling, cultural aspects are critical contextual components to be considered. In Asian cultures, high levels of disgrace are associated with individuals who seek assistance from professional mental health care providers. Being stigmatized for seeking professional mental health care may result in those reluctant to seek it. Yoon and Jepsen (2008) conducted a survey of 189 Asian international (e.g., Chinese, Korean, Taiwanese, Japanese) and 186 United States students to explore international students’ expectations of and attitudes toward counseling, especially regarding help seeking. Related to direct or indirect experience with counseling, there were significant differences between U. S. students and international students ( $\chi^2=71.65$ ,  $p<0.001$ ). More U.S. students (45.2%) have experienced counseling than international students (6.9%). In addition, compared with U. S. students, more Asian students reported a lack of self-perceived need for counseling, discomfort/shame related to counseling, less openness to counseling, and a greater preference for directive style. Along with culture, immigrants socioeconomic and immigration status, English proficiency, health care may be another important factor to be considered to provide effective services to immigrant population (Derose, Escarce, & Lurie, 2007). Asian students agreed or strongly agreed with concerns with language barriers (e.g., ability to communicate in English

with a counselor) and counselor's cultural sensitivity due to cultural differences (Yoon & Jepsen, 2008).

Considered as a *collectivistic hierarchical culture*, individuals in Korean culture have a tendency to believe that counselors have more power and authority in a counseling session, and clients may be insecure with counselors (Yoo & Yoo, 2000). Yoo, Goh, and Yoon (2005) conducted a study with 64 male and 98 female undergraduate students (N=162) in South Korea to investigate the influence of gender, cultural and personal psychological variables on counseling seeking attitudes in Korea. Korean students who experience emotional distress in the study reported actually seeking counseling but may have negative attitudes regarding counseling and may present greater resistance toward seeking help. The findings of study also indicate Korean experience difficulties in disclosing mental problems to professionals. Similarly, Bernstein (2007) conducted a survey with 34 Korean female immigrants to explore their perception and understanding of mental health and illness (e.g., depression, child and adolescent problem, coping with family issues, alcoholism). Even though participants acknowledged the need for professional help, the majority of participants (68%) stated negative perceptions regarding receiving or considering counseling or professional help. As a barrier to receiving counseling, participants reported a lack of motivation for help-seeking or a refusal of counseling by a family member, time and financial constraints, general difficulty in help seeking, and no reliable and trustworthy organization available. However, when professionals as a mediator create culturally responsive and positive environment in counseling, clients become more engaged in sharing their experiences (Bernstein, 2007) and clients' expectations of counseling increase and gain positive outcomes from counseling (Yoo, Hong, Sohn, & O'Brien, 2014).

## **Gestalt Theory**

Because of Korean immigrants' resistance to various forms of counseling, they may not become aware of their feelings and needs. It is important to have culturally appropriate approaches to allow them to become aware of their feelings and needs. This is one goal of Gestalt theory and therapy. Gestalt is a German word for which there is no exact English translation, but *Gestalt* roughly means a whole, shape, pattern or a form that cannot be divided into parts without losing its core (Corey, 2013b; Levine, 2012; Masquelier, 2015; Mayhew, 2009). Gestalt theory stresses the need for people to recognize events as whole, or greater than the sum of their individual parts (Kohler, 2015; Mayhew, 2009; Van Boven & Epley, 2003; Yontef & Jacobs, 2010). The essential principles of Gestalt theory were developed by the German psychologists Max Wertheimer, Kurt Koffka, and Wolfgang Kohler in the early twentieth century (Colman, 2015; Longe, 2016). The Gestalt psychologists believed that "the mind consists of separate units or elements that can be understood by mapping and studying them in combination" (Longe, 2016, p. 478).

**Gestalt therapy.** According to Levine (2012), the term currently used to describe the Gestalt theory in the field of psychology is Gestalt therapy. *Gestalt therapy* is an experiential form of psychotherapy that helps individuals focus on the present and become aware of their psychological and physical needs in the present moment (Colman, 2015; Longe, 2016; Kohler, 2015; Mayhew, 2009; Van Boven & Epley, 2003; Yontef & Jacobs, 2010). Gestalt therapy was developed by Frederick (Fritz) Perls and Laura Perls in the 1940s and stresses dialogue and relationship between client and therapist (Buren & Wienclaw, 2012; Corey, 2013b; Yontef & Jacobs, 2010).

Gestalt therapy is comprised of principles and elements from a variety of philosophies (Colman, 2015; Longe, 2016; Kohler, 2015; Mayhew, 2009; Van Boven & Epley, 2003; Yontef

& Jacobs, 2010). According to Corey (2013b), Gestalt therapy is “an existential, phenomenological and process-based approach created on the premise that individuals must be understood in the context of their ongoing relationship with the environment” (Corey, 2013b, p. 212). The key elements of Gestalt therapy include phenomenological, experiential, humanistic, and existential approaches (Brownell, 2010; Corey, 2013b; Oaklander, 2003; Polster & Polster, 1978; Yontef & Jacobs, 2010; Zinker, 1977). The phenomenological approach in Gestalt therapy focuses on the clients’ perception of reality (Brownell, 2010; Corey, 2013b; Zinker, 1977). Phenomenology emphasizes whatever is occurring now and does not focus on the past; however, the phenomenological approach motivates individuals to look forward to real experiences that are as yet to come (Brownell, 2010; Corey, 2013a; Zinker, 1977). The experiential approach in Gestalt therapy stresses awareness and integration that helps clients to understand what and how they are thinking, feeling, and doing with others in the world (Brownell, 2010; Corey, 2013a). As an experiential approach, Gestalt therapy pays attention to the here and now and stress awareness, personal choice, and responsibility (Corey, 2013c). The humanistic aspect of the Gestalt therapy focuses on an individual’s “gaining on awareness of emotions and behaviors in the present rather in the past” (Doermann, 2015, p. 2172). The humanistic approach emphasizes growth and acceptance, which views human nature as essentially positive and fundamentally good (Center for Substance Abuse Treatment, 1999; Corey, 2013b; Oaklander, 2003; Levine, 2012; Yontef & Jacobs, 2010). The existential aspect of Gestalt therapy emphasizes that every individual has responsibility, unique experiences, and freedom (Center for Substance Abuse Treatment, 1999; Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). As an existential approach, Gestalt therapy is grounded in the belief that individuals are “always in the process of becoming, remaking, and rediscovering themselves” (Corey, 2013b, p. 212).

Approaches to Gestalt therapy highlight that an individual has “the capacity for self-awareness and choice” (Center for Substance Abuse Treatment, 1999, p. 105) and emphasize an individual’s awareness of what he or she is experiencing and doing (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). A main element in these approaches of Gestalt therapy is to assist clients to come to awareness of what they are doing and experiencing (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). The approaches of Gestalt therapy stress the process of therapy more than the content of it (Corey, 2013b; Mayhew, 2009; Yontef & Jacobs, 2010). Gestalt therapy is active, and counselors are encouraged to direct the clients to experience rather than just talk about circumstances (Corey, 2013b).

*View of human nature.* Gestalt therapy’s view of human nature is rooted in phenomenological, existential, and field theory (Brownell, 2010; Corey, 2013b; Mayhew, 2009; Oaklander, 2003; Polster & Polster, 1978; Yontef & Jacobs, 2010). Gestalt therapy basically believes that the individuals can deal with their problems or issues if the individuals become aware of what is happening within themselves and outside of themselves (Corey, 2013b; Mayhew, 2009; Oaklander, 2003; Polster & Polster, 1978; Yontef & Jacobs, 2010). Gestalt therapy posits that an individual has the capacity to self-regulate for growth and healing from the individual’s environment (Corey, 2013b; Yontef & Jacobs, 2010; Zinker, 1977). According to Corey (2013b), Gestalt therapy is a process of reowning part of oneself that have been disowned. Additionally, this unification process promotes individuals to become strong enough to proceed and carry the weight of their own personal growth (Corey, 2013b; Yontef & Jacobs, 2010).

Gestalt therapy theorizes that problems develop when a person tries to be who or what he or she is not (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt therapy stresses that authentic change occurs more when an individual become fully aware of who and what he or she is and as opposes changing into who or what he or she is not (Beisser, 1970). According to Corey (2013b),

it is important for individuals “to be as fully as possible in their current condition, rather than striving to become what they should be” (p. 214). The aim of Gestalt therapy is to assist clients to gain awareness of how they are functioning or working with family or friends in their environment (Buren & Wienclaw, 2012; Corey, 2013b; Yontef & Jacobs, 2010).

Gestalt counselors see each person as a unified and coherent whole, and “the whole is different from the sum of its parts” (Corey, 2013b, p. 214). Gestalt counselors are interested in the whole person and do not focus on a particular aspect of the individual (Corey, 2013b). Additionally, Gestalt counselors pay attention to clients’ experiences in terms of their thoughts, feelings, perceptions, behaviors, body sensations, memories, and dreams (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt therapy is rooted in field theory, which stresses that each organism is a part of a continuously changing field, and that each organism must be seen in its environment or in its context (Brownell, 2010; Corey, 2013b; Yontef & Jacobs, 2010). Field theory is “a theory about the nature of reality and our relationship to reality” (Yontef & Jacobs, 2010, p. 329). Gestalt counselors attempt to discover what is occurring at the boundary between the client and the environment (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt therapy views that an individual mainly perceives the aspects of experience in which he or she is most interested (Corey, 2013b). Other aspects of experience only provide a background which is often outside of the individual’s awareness.

Gestalt therapy focuses on a way in which the individual organizes experiences and interprets experiences from moment to moment (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt counselors promote clients’ movement toward and away from the issues (Corey, 2013b; O’Leary, 2013; Yontef & Jacobs, 2010). Additionally, the Gestalt counselors believe that individuals are self-regulated and motivated by the emergence of their needs, sensations, and interests (Corey, 2013b; Yontef & Jacobs, 2010; Zinker, 1977). Having clients know what they sense, feel,

observe, need, want, and believe is required for self-regulation (Corey, 2013b; Yontef & Jacobs, 2010; Zinker, 1977). According to Yontef and Jacobs (2010), actual growth is beginning with “conscious awareness of what is occurring in one’s current existence, including how one is affected and how one affects others” (p. 329). Therefore, Gestalt counselors assist clients in working on awareness of their interests and needs and their ability to regain a sense of balance in their lives (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt therapy focuses on the here and now, the what and how, and the relationship between counselor and client (Corey, 2013b; Levine, 2012; O’Leary, Sheedy, O’Sullivan, & Thoresen, 2003).

Gestalt counselors emphasize the present moment and believe that power is in the present (Polster & Polster, 1973). Commonly, individuals focus on their past mistakes by thinking about how their lives could and should have been different, or they focus on making plans to live in the future (Corey, 2013b; Polster & Polster, 1973; Yontef & Jacobs, 2010). Reliving the past and worrying about the future decrease the power of the present and interfere with an individual’s ability to make authentic change and become aware of who he or she is (Corey, 2013b; Polster & Polster, 1973; Yontef & Jacobs, 2010). In Gestalt therapy, nothing exists except the present because the past is gone and the future has not yet come (Corey, 2013b; Polster & Polster, 1973; Yontef & Jacobs, 2010). According to Corey (2013b), individuals usually discuss their feeling as if they are separated from their current experiences and have difficulty experiencing their feelings in the here and now. Counselors who practice Gestalt therapy assist clients in becoming aware of their present experience (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt counselors ask “what” and “how” questions instead of “why” questions to help clients connect with the present (Corey, 2013b; Yontef & Jacobs, 2010). Questions such as “what is going on now?” and “what are you experiencing as you sit there” are used to promote clients’ awareness of the present (Corey, 2013b; Yontef & Jacobs, 2010). Instead of neglecting or disregarding the individuals’

past, Gestalt counselors recognize the past as an important influence that creates the individuals' present attitudes and behaviors (Corey, 2013b; Yontef & Jacobs, 2010). Gestalt counselors encourage dialogue in the present by asking the clients to bring the past into the present moment by reenacting it as though the clients were living it in here and now (Corey, 2013b; Yontef & Jacobs, 2010).

One of the important concepts in Gestalt therapy is unfinished business, which is defined as unexpressed feelings, including resentment, rage, hatred, pain, anxiety, grief, guilt, and abandonment (Corey, 2013b; O'Leary, 2013; Polster & Polster, 1973). These feelings are not fully experienced are in clients' awareness. They remain in the background and are carried into the present life in ways that interfere with successful contact with an individual's self and others (Corey, 2013b; O'Leary, 2013; Polster & Polster, 1973). Unfinished business remains until an individual confronts and deals with the unexpressed feelings and displaces some blockage within the body (Corey, 2013b; O'Leary, 2013; Polster & Polster, 1973). According to Corey (2013b), Gestalt counselors stress "the bodily experience on the assumption that if feelings are unexpressed they tend to result in some physical sensations or problems" (p. 216). When individuals are in a difficult situation in which it seems impossible to make any progress, or when external support is not available, individuals reach an impasse (Corey, 2013b). During the impasse, an individual is unable to engage in a new constructive behavior or move forward though fear or panic (O'Leary, 2013). Gestalt counselors help clients by providing environments that encourage clients to fully experience their condition of being at this impasse (Corey, 2013b; O'Leary, 2013; Polster & Polster, 1973). The clients are able to connect to their frustrations, admit the unfinished feelings rather than wishing they were different, and start to think, feel, and act differently if they accept all conditions of themselves without judging these unexpressed



feelings (Corey, 2013b; O'Leary, 2013; Polster & Polster, 1973). This new state helps clients to experience growth and actualization.

**Contact and resistance.** One concept emphasized in Gestalt therapy is contact, which means “being in touch with what is emerging here and now, moment to moment” (Yontef & Jacobs, 2010, p.330). Gestalt therapy stresses that change and growth do not exist without contact, which is built by seeing, hearing, smelling, touching, and moving (Corey, 2013b; Polster & Polster, 1973). Contact does not simply mean togetherness or joining; it occurs only “between separate beings, always requiring independence and always risking capture in the unions” (Polster & Polster, 1973, p. 99). According to Corey (2013b), the effective contact exists when the individuals interact with nature and with others without losing one’s individuality. Individuals cannot function in a healthy manner without both contact and withdrawal (Corey, 2013b).

Corey (2013b) stated that Gestalt counselors attend to interruptions, disturbances, and resistance to contact, which are coping processes, but often prevent individuals from experiencing the present fully. Resistance is defined as “an awkward but crucially important expression of the organism’s integrity” (Yontef & Jacobs, 2010, p. 342). Resistance is an unaware conflict within an individual that can develop out of dysfunctional behavior (Corey, 2013b). Additionally, resistance is the process against “the formation of a figure (a thought, feeling, impulse, or need) that threatens to emerge in a context that is judged to be dangerous” (Yontef & Jacobs, 2010, p. 342).

Polster and Polster (1973) introduced five channels of resistance interaction that disrupt the cycle of experience. These are introjection, projection, retroflection, deflection, and confluence. *Introjection* is “the tendency to uncritically accept others’ beliefs and standards without assimilating them to make them congruent with who we are” (Corey, 2013b, p. 217).

Introjection commonly occurs to the children who automatically do everything their parents tell them to do or demonstrate to them. For example, children might assume their parents' personalities, political beliefs, concepts of right and wrong, or religious ideas. *Projection* is the opposite of introjection. Projection means that individuals disown or alienate certain aspects of the self by assigning these aspects to the environment (Corey, 2013b; Polster & Polster, 1973; Zinker, 1977). Projection occurs when an individual refuses or avoids a quality or aspect of the self and effectively projects that quality or aspect onto others without self-awareness (Corey, 2013b; Polster & Polster, 1973; Zinker, 1977). For example, individuals who use projection tend to assume that others are tired or bored when they feel tired or bored. Retroreflection is "turning back onto ourselves what we would like to do to someone else or doing to ourselves what we would like someone else to do to or for us" (Corey, 2013b, p. 218). Individuals who rely on retroreflection tend to restrain themselves from taking action out of fear of embarrassment, guilt, and resentment (Corey, 2013b; Polster & Polster, 1973; Zinker, 1977). For example, if an individual becomes angry with his or her boss and holds this anger a long time, it may result in depressed feelings or psychosomatic complaints (Corey, 2013b; Polster & Polster, 1973).

*Deflection* is characterized by a "process of distraction or veering off, so that it is difficult to maintain a sustained sense of contact" (Corey, 2013b, p. 218). According to Polster and Polster (1973), deflection is any behavior that turns one aside from direct contact with other or environment. Individuals who rely on deflection tend to change the subject in conversation to limit contact (Corey, 2013b; Polster & Polster, 1973). Confluence refers to "a phantom pursued by people who want to reduce difference so as to moderate the upsetting experience of novelty and otherness" (Polster & Polster, 1973, p. 92). Individuals who rely on confluence blur boundaries so that is difficult to differentiation between the self and the environment (Corey, 2013b; Polster & Polster, 1973; Zinker, 1977). For example, individuals who rely on confluence

may lack conflicts in their relationships or believe that everyone experiences the same feelings and thoughts. Gestalt counselors encourage clients to become aware of their main methods of resistance that block contact. In Gestalt therapy, it is important to attend to how clients interrupt contact and discover what the resistance does for clients (Corey, 2013b; Polster & Polster, 1973).

***Therapeutic goals and counselor's roles.*** The basic goal of Gestalt therapy is to help clients increase awareness and acceptance of the present self (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs; Zinker, 1977). Gestalt counselors assist clients to obtain greater awareness, including knowledge of the environment and knowledge of oneself; develop greater self-acceptance; and increase the ability to make contact (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977). Additionally, Gestalt counselors promote a non-judgmental self-awareness that encourages clients to develop a unique perspective on life (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977). According to Zinker (1977), individuals are asked to work on the following areas: moving towards increased awareness of self; taking ownership of personal experiences; building skills to satisfy their needs without disrupting the rights of others; increasing awareness of all senses; learning to take responsibility for personal actions; and increasing the ability to ask for and receive help from others. In Gestalt therapy, individuals learn to become aware of what and how they are doing, how they change themselves, and how they accept themselves (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977). Individuals are also encouraged to develop or regain their ability to cope (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977). The aim of Gestalt therapy is not analysis; its aim is to increase contact with and awareness of both the internal and external world (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977).

According to Zinker (1977), Gestalt counselors are creative therapists, choreographers, historians, phenomenologists, students of the body, dramatists, thinkers, theologians, and

visionaries. Gestalt counselors help their clients create journeys in which the clients can express themselves behaviorally (Corey, 2013b; O'Leary, 2013; Yontef, 1993; Yontef & Jacobs, 2010; Zinker, 1977). Yontef and Jacobs (2010) suggested that Gestalt counselors use active methods that help individuals develop awareness, freedom, and self-direction, rather than directing them toward preset goals. Counselors are actively and personally engaged with clients and encourage clients to pay attention to their sensory awareness in the present moment (Corey, 2013b; O'Leary, 2013; Yontef & Jacobs, 2010; Zinker, 1977).

Yontef (1993) stated that the clients in the Gestalt therapy do the basic work of psychotherapy even though the counselors act as guides and catalysts by presenting experiments and sharing observations. They do not force change on clients through confrontation (Corey, 2013b; Yontef, 1993; Yontef & Jacobs, 2010; Zinker, 1977). Instead, they focus on each individual's awareness and contact processes with respect, empathy, and commitment to the individual's subjective reality (Yontef & Jacobs, 2010). Additionally, they attend to their clients' body languages that provide rich information about hidden feelings. Non-verbal languages including movements, postures, and gestures that express important messages about feelings attach to behaviors and inner meanings (Corey, 2013b).

The functions and roles of Gestalt counselors are: to assist individuals in increasing their self-awareness; to encourage and help individuals to focus on the here and now; to pay attention to individuals' verbal and non-verbal language; to listen closely and non-judgmentally; to encourage individuals to learn to self-regulate; to avoid interpretation and explanation of the dynamics of an individual's behavior; to create a safe environment for individuals to identify and explore their thoughts, feelings, and perceptions in the present moment; to fully participate in the individuals' experience without becoming involved; to engage in open dialogue; and to share

individuals' experiences, including observations, emotions, thoughts, and perspective (Corey, 2013b; Yontef, 1993; Yontef & Jacobs, 2010; Zinker, 1977).

Gestalt therapists and their clients use creative and experiential techniques to enhance awareness, freedom, and self-direction (Corey, 2013b). The relationship between counselor and client in Gestalt therapy is equal and person-to-person (Corey, 2013b). The counselor's presence is more important than technical skills (Corey, 2013b; Yontef, 1993; Yontef & Jacobs, 2010; Zinker, 1977). Building a trusting relationship between the counselor and the client helps the client to be able to achieve higher levels of awareness (Corey, 2013b; Yontef, 1993; Yontef & Jacobs, 2010; Zinker, 1977). In summary, Gestalt therapy is an experiential approach that emphasizes self-awareness and the quality of contact between self, others, and the environment (Corey, 2013b). The major goal of Gestalt therapy is to help individuals to become aware of what they are experiencing and how they are experiencing it (Corey, 2013b). Individuals gain awareness and explore how they contact with self and other (Corey, 2013b).

**Group counseling.** Group counseling is a form of counseling where two or more individuals meet regularly to interact and connect with others and the group leader (Bussmann, 2014; Forsyth, 2010; Gladding, 2016a). Groups work with diverse individuals including age, ability, disability, problems, issues, socioeconomic status, level of education, race, ethnicity, sexual identity, and cultural background (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Groups have been held in various settings including school, hospital, and community agencies (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Groups have been utilized for therapeutic or educational aim or for a combination of the two (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Some groups are designed to help individuals to experience fundamental changes in their thinking, feeling, and behaving (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). For example, groups for educational purposes can be used for individuals to encourage

developing specific coping skills (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a).

Group counseling is “the development of an interpersonal network” (Trotzer, 2013, p. 20) that creates an atmosphere of trust and acceptance to link and work together between each member to one another and to the whole group (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

Group counseling is designed to target a specific issues (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a) including depression (e.g. Chu et al., 2014; Choi, Lee, & Lim, 2008; Duarte, Miyazaki, Blay, & Sesso, 2009), post-traumatic stress disorder (PTSD) (e. g. Hansen, 2006; Schnurr et al., 2003), social anxiety (e.g. Blanco et al., 2010; Kocovski, Fleming, & Recotor, 2009), and sexual abuse (e.g. Dietz, Davis, & Pennings, 2012; Classen et al., 2011). Additionally, group counseling is designed to meet the needs of specific populations (Bussmann, 2014; Corey, 2016; Forsyth, 2010) including children (e.g. Kim, Kirchhoff, & Whitsett, 2011; Riley, 2013), adolescents (e. g. Green et al., 2011; Hazell at al., 2009; Riley, 2013), elderly people (e. g. Lin et al., 2011; Riley, 2013), males (e.g. Gannon et al., 2015; Scheinfeld, Rochlen, & Buser, 2011) or females (e.g. Brotto, Basson, Smith, Driscoll, & Sadownik, 2015; Kissane et al., 2007; Riley, 2013).

***Goals and benefits of group counseling.*** Groups are usually created for a reason and individuals who participate in a counseling group seek the specific goals of the group for their needs (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). According to Corey (2016) and Forsyth (2010), the possible goals of counseling groups are:

- For awareness and self-knowledge
- To recognize and understand individuals’ and group members’ needs and problems
- To assist individuals and group members to increase self-acceptance, self-confidence, and self-regulate

- To learn how to express individual feelings and thoughts regarding in a healthy living
- To understand and confront unsatisfactory or problem areas in one's life
- To develop successful coping strategies of dealing with certain conflicts
- To create supportive and effective network

According to Burlingame, Mackenzie, and Strauss (2004), group counseling has been recognized as a beneficial and effective approach to treatment. Group counseling provides support, rich feedback, and understanding that help individuals to realize that they are not only one who experiences difficulties or who are faced with similar challenges or issues (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Individuals experience belonging and cohesion through ways of learning, caring, challenging, and being intimate in the group counseling (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Group counseling also offers opportunities to develop new behaviors, new social skills, and new relationships while participating (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Individuals may receive encouragement from others in the group and learn how other members practice their new behaviors and decisions (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Additionally, individuals may experience a wide variety of backgrounds, information, and experiences during the group experience (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a).

Group counseling can be successfully used for presentational and educational purposes with effective approaches, including the group counselor's adequate preparation, training, and supervision to help individuals (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Therefore, it is necessary that group counselors prepare adequate knowledge and skills as being an effective group leader (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a).

*Types of group work.* Counseling groups focus on prevention, growth, development, enhanced understanding, and self-awareness (Bussmann, 2014; Corey, 2016; Forsyth, 2010; Gladding, 2016a). Counseling groups, which are referred to as interpersonal problem-solving groups, focus on each individual's "behavior and development or change within the group and through the help of the group" (Gladding, 2016a, p. 31). Counseling groups emphasize the entire group even though the aims of the groups are personal (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Counseling groups may focus on an individual's challenges to deal with emotions including anger, fear, and anxiety (Corey, 2016; Forsyth, 2010; Gladding, 2016a). This type of groups also stresses group dynamic and interpersonal relationship (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Counseling groups usually focus on developmental or situational topics including educational, social, career, and personal. Counseling groups work with individuals of all ages and range from three to four individuals for children's groups to eight-to-nine individuals for adult group (Forsyth, 2010; Gladding, 2016a).

Another type of groups is a psychotherapy group called group psychotherapy or group therapy. Group psychotherapy is focused on remediation, treatment, and personality reconstruction (Corey, 2016). Group psychotherapy aims to re-educate and provide information for individuals with serious psychological problems or specific issues including "both conscious and unconscious awareness and both the present and the past" (Corey, 2016, p. 7). Individuals who fit in this type of groups may experience long-term and severe emotional problems, deep personal conflicts, trauma, or psychotic states. Group therapy is mostly found in mental health facilities such hospitals and clinics either open ended, which admits new group members at any time, or close ended, which does not admit new group members after the first session (Forsyth, 2010; Gladding, 2016a). A group counselor or facilitator of group therapy is typically a clinical practitioner who is a licensed professional counselors or clinical social worker. Group counselors



and facilitators of group therapy utilize a wide range of approaches and modalities that help individuals in developing health decisions about the world, others, and self (Forsyth, 2010; Gladding, 2016a). The size of group therapy varies from two or three to twelve members (Forsyth, 2010; Gladding, 2016a).

Psychoeducational groups were developed for educational aim especially public school (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Psychoeducational groups are simply referred to as structured, educational or guidance groups. They impart factual information to the groups through presentations and discussions. The aims of psychoeducational groups are to provide information, share common experiences, offer support, and teach how to work with problems and how to help members develop their own support systems outside of the group setting (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Psychoeducational groups are designed to assist individuals to establish specific skills, understand certain subjects, or progress through difficult life transitions (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Psychoeducational groups aim to prevent any educational disturbances and psychological disorders and contain certain content about subjects to provide structure sessions (Corey, 2016; Forsyth, 2010; Gladding, 2016a). The purpose of this type of group can be designed to meet the needs of every individual in the group (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

Task groups are designed to help “task forces, committees, planning groups, community organizations, discussion groups, study circles, learning groups, team building, program development consultation, and other similar groups to correct or develop their functioning” (Corey, 2016, p. 9). Task groups can be volunteer groups, mission groups, goal groups, or working groups (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Task groups focus on the application of principles and processes of group dynamic that promote individuals to achieve identified work aims (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Task groups often work to

meet the needs of a community and have many been used in community interventions (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Task groups depend on strong relationships among members and between members and group leaders (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Unlike other groups, task groups do not focus on individuals' personal change, but work together to reach to the goals of groups (Corey, 2016; Forsyth, 2010; Gladding, 2016a). The guiding principles of warm-up, action, and closure help the group to keep the balance between content and process in the task groups (Corey, 2016; Forsyth, 2010; Gladding, 2016a). According to Corey (2016), group leaders need to understand how sociopolitical influences may affect the individuals' experiences from diverse racial and ethnic groups.

To increase the probability of a successful group experience for all members, most group workers must spend time and energy to preplan part of the group, group structure, group exercise, group interaction, and members' roles (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Additionally, group workers need to clarify the group's purpose, group settings, the length of the group meeting, size of group, voluntary or mandated attendance, openness, and benefits and risks of group before starting the groups (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

**Group counselor.** The group counselor also needs to have acquired extensive theoretical and practical knowledge of group dynamics (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Becoming an effective group counselor, the counselor must emotionally and physically engage with the group to demonstrate a genuine caring and willingness to join the group members' psychological world. Effective group counselors understand the power of self-confidence and an awareness of one's influence on others as a group leader (Corey, 2016; Forsyth, 2010; Gladding, 2016a). They also believe in the power of equality within the group and encourage members to get in contact with their own power, so as not to become dependent on someone else. Effective

group counselors use courage and respect in their interactions with group members (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

According to Skovholt and Jennings (2004), highly effective group counselors have the following abilities. They: (1) provide a safe environment for the group members while working with challenging issues; (2) accept feedback about themselves without destabilizing the group's focus; and (3) maintain personal and professional boundaries. The essential skills of the group involve active listening, restating, clarifying, summarizing, appropriately questioning, interpreting, confronting, reflecting feelings, supporting, empathizing, facilitating, initiating, evaluating, setting goals, specific and honest feedback giving, suggesting, protecting, and effectively disclosing oneself (Corey, 2016; Forsyth, 2010; Gladding, 2016a).

The group counselors became aware of the guidelines how to effectively serve diverse clients. The counselors also must be aware of their own cultural background and assumptions, especially while working with people from diverse cultures, ethnicities, races, genders, classes, religions, and sexual identities (Corey, 2016; Forsyth, 2010; Gladding, 2016a). Corey (2016) suggests that group counselors think about how their assumptions may affect group members. Additionally, group counselors must become aware of multicultural perspectives, cultural norms, and different values to understand various members in the group.

**Expressive techniques.** Counselors and mental health practitioners work with various clients and diverse environment where talking is the traditional method of communications. However, verbal techniques do not always deliver sufficient meaning (Bradley, Whiting, Hendricks, Parr, & Jones Jr, 2008; Malchiodi, 2005). Sometimes individuals feel uncomfortable or uneasy verbalizing their emotions and thoughts (Bradley et al., 2008; Malchiodi, 2005).

In such cases where verbal communication is not sufficient, according to Malchiodi (2005), individuals may express in different ways such as using more visual and/or tactile

communication. Additionally, individuals from certain cultures may express their feelings or thoughts in a culturally different way (Lim, 2016). For example, a person from an individualist culture may express his or her inner states or feelings to others (Tsai, Miao, Seppala, Fung, & Yeung, 2007). By contrast, individuals from a collectivistic culture may regulate, change, or express their feelings to fit the groups they are in (Tsai et al., 2007). Cultural differences may influence emotional expression, facial expression, and recognition of emotions (De Leersnyder, Boiger, & Mesquita, 2013; Kitayama, Markus, & Kurokawa, 2000; Matsumoto, 1991; Matsumoto & Ekman, 1989).

Counselors have recognized the limitation of verbal language to express and describe the full range of an individual's emotions and experience (Gladding, 2016b). Malchiodi (2005) suggests that if the counselors can provide various and alternative ways for clients to express themselves, the clients can communicate with their counselors more effectively and authentically. Practitioners in the fields of psychology, psychiatry, social work, counseling, nursing, and medicine have used various creative and expressive activities to help individuals of all ages (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2005).

Creative and expressive techniques have opened a new chapter and added an important dimension to counseling (Bradley et al., 2008). They offer non-verbal approaches that can be used in a wide variety of therapeutic settings (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2005). Expressive techniques include drawing, art, integrated arts, music, drumming, cinema, drama, storytelling, writing, creative movement, play, and sandtray with individuals of all ages. These help individuals express their emotions and thoughts in a unique way (Bradley et al., 2008; Malchiodi, 2005).

Expressive techniques integrate following modalities in counseling:

- With art that uses “art media, images, and the creative process, and respects patient/client responses to the created products as reflections of development, abilities, personality, interests, concerns, and conflicts” (Malchiodi, 2005, p. 22).
- With music that involves creating, singing, and/or listening to music within a therapeutic relationship to work on individuals’ physical, emotional, cognitive, and social needs (American Music Therapy Association, What is Music Therapy, 2018).
- With drama that is an active and experiential approach that individuals tell their stories, set goals and solve problems, express feelings, or achieve catharsis through drama. Individual also develop their repertoire of dramatic roles to find their own life roles have been strengthened” (The North American Drama Therapy Association, What is Drama Therapy?, 2018).
- With dance and movement that uses movement and/or dance to encourage individuals to express their emotions and inner conflicts through dance (Colman, 2015).
- With writing that uses such forms as poetry, journals, letter, and other form of literature to support individuals for healing and personal growth (Feldman, 2011; Malchiodi, 2005).
- With play that uses selected play materials and develop a dynamic interpersonal relationship with individuals all ages, especially children, to encourage expressing and exploring self, feelings, thoughts, and experiences (Landreth, 2012).
- With sandtray that is “a creative form of psychotherapy that uses a sandbox and a large collection of miniatures to enable a client to explore the deeper layers of the psyche in a totally new format” (Malchiodi, 2005, p.23).

- With multimodal means that involves two or more expressive techniques to develop awareness, encourage growth, and improve relationship with others (Malchiodi, 2003).

Expressive techniques are both nonverbal and verbal communication modalities to share thoughts and feelings between counselors and individuals. Expressive techniques have been recognized by practitioners in the fields of psychology, psychiatry, social work, counseling, nursing, and medicine for children, who have limited language or language barriers, and elderly individuals, who have lost the ability to talk because of mental or physical issues including a stroke, dementia, or a trauma (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). Expressive techniques might promote individuals, who may experience difficulties to express their feelings and thoughts into speech, express through arts, music, movement, and/or play (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). Additionally, expressive techniques may be used with individuals, families, or group goals like general counseling (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005).

The goals of expressive techniques in counseling are self-expression, active participation, imagination, and mind-body connections (Malchiodi, 2005). First, utilizing expressive techniques encourages individuals to engage in self-exploration and self-expression through one or more modalities as therapeutic process (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). According to Malchiodi (2015), self-expression is “a container for feelings and perceptions that may deepen into greater self-understanding or may be transformed, resulting in emotional reparation, resolution of conflicts, and a sense of well-being” (p. 9). The role of counselors who utilize expressive techniques facilitate individuals to explore personal meaning and understanding in their life and interpret individuals’ drawings, movement, poems, or play (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). Counselors also assist

individuals to become aware their experiences, feelings, and perceptions (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). Second, utilizing expressive techniques encourage individuals to become fully and actively participate and present in the present therapeutic process (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). All forms of expressive techniques including art, music making, dance and drama, and creative writing require the investment of individual's because experience of doing, making, and creating actually demand energy for redirecting attention and focusing, reducing emotional stress, allowing fully concentrate on issues, goals, and behaviors (Bradley et al., 2008; Gladding, 2016b; Malchiodi, 2003, 2005). Third, utilizing expressive techniques helps individuals "in moving beyond their preconceived beliefs through experimentation with new ways of communication and experiences that involve pretend" (Malchiodi, 2005, p. 11). Individuals use imaginative thinking to create self-expression, experimentation, and successively verbal reflection (Malchiodi, 2003, 2005). According to Malchiodi (2005), imaginative thinking helps individuals to make drawings, create a movement, or employ figures to develop the possibility and capability of creating inventive solutions and transformation. Last, utilizing expressive techniques helps individuals reconnect with their mind and body in therapeutic process. Individuals may experience the body's relaxation, a calm and confident state being related to perception of health and well-being. Expressive techniques encourage individuals to connect with their body and mind's sensory experiences, interactions, movement, and movement activities. Additionally, expressive techniques assist individuals to repair and reshape their body and mind through sensory experience (Malchiodi, 2003, 2005).

Korean culture is deeply affected by Confucianism whose emphasis is on family structure, gender roles, social behavior, ethics and moral principles (Kim, 2009; Park & Cho, 1995). Components of Confucianism include respecting seniority, age differences, a hierarchical

relationship, and group harmony (Kim, 2009; Lee, 2001; Park & Cho, 1995). Korean culture normally does not accept individualism, self-respect, and freedom (Kim, 2009; Lee, 2001; Park & Cho, 1995). Because of these cultural limitations, many Korean immigrant women have difficulties with self-disclosure and verbal expression regarding their feelings and thoughts. Additionally, Korean immigrant women may feel that there is a large power differential and hierarchical social relationship between counselors and clients (Kim, 2009; Lee, 2001; Park & Cho, 1995). Korean immigrant women may be afraid of self-expression regarding expressing their needs, opinions, or feelings to the counselors because of their cultural perception. However, Korean culture traditionally allows expression of individual's feelings and thoughts through expressive activities including music, instruments, dances, stories and paints.

Koreans culturally and historically express their feelings and thoughts through singing and dancing to confront difficulty or to celebrate fortune (Jeong, 2014; Lee, 2001). For example, Korean farmers dance and sing with people during the special ceremonial rites of the villages such as wish for a good harvest, pray for the fecundity, and wish for good health and longevity (Jeong, 2014; Lee, 2011). Some people wear masks when they dance or play a drama (Lee, 2011). Koreans also decorate a big tree for celebration or remembering a situation or event in their life (Lee, 2011). Expressive techniques may help Korean immigrant women explore their emotions and experience and understand their mental health issues with less resistance to therapy.



### **CHAPTER III: RESEARCH METHODS**

This chapter describes the methodology of the study. The study research design, sampling methods, and data collection methods are described. The study instruments are discussed, and the methods to analyze the data are presented.

The purpose of the current study is to evaluate the relationship between acculturative stress and depressive symptoms in Korean immigrant women and to evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. The hypotheses of this research study were:

- 1) Acculturative stress is positively related to depressive symptoms in Korean women who have immigrated to the United States and live in the southern and central regions of Texas.
- 2) There is a significant difference in changes in acculturative stress for Korean women who immigrated to the United States and participated in expressive group counseling interventions than for Korean women who immigrated to the United States and did not participate in expressive group counseling interventions.
- 3) There is a significant difference in changes in depressive symptoms for Korean women who immigrated to the United States and participated in expressive group counseling interventions than for Korean women who immigrated to the United States and did not participate in expressive group counseling interventions.

Pre- and post-test control group design were utilized in this study to investigate the effect of the independent variable, expressive group counseling interventions, which was reflected in the differences on the dependent variables, specifically between the levels of acculturative stress and depressive symptoms among Korean immigrant women either in the intervention group or in

the control group. Participants were randomly assigned to an intervention and a control groups. The intervention group received expressive group counseling interventions while a control group received none. Both the intervention and control groups received a pre-test before the interventions and administered a post-test after the interventions.

This study developed total of four sessions of expressive group counseling interventions for Korean immigrant women in the intervention group and no intervention for Korean immigrant women in the control group. The study examined the preliminary impact of expressive group counseling interventions on acculturative stress and depressive symptoms among Korean immigrant women in the United States. Each session of expressive group counseling interventions utilized with expressive interventions approximately 90 minutes (1.5 hours). The four expressive group counseling interventions included drawing, painting, sandtray therapy, writing, meditation, mindfulness, drumming, and body movement: (1) the first session created a mask, (2) the second session built a world in sandtray therapy, (3) the third session created a mandala, and (4) the fourth session created a tree. Participants in the intervention group were asked to write their experience of using expressive interventions in the group counseling setting, and feelings with the group members. After participating in expressive interventions, the researcher invited participants in the intervention group to voluntarily share about their experience at the expressive group counseling interventions.

Expressive group counseling interventions in this study focused on self-awareness and self-expression of an individual's development and maintenance relationship in the person's daily life, which is based on Gestalt therapy (Masquelier, 2015; Polster & Polster, 1978; Zinker, 1977).

### **Research Design**

This study used a pilot experimental design using a pre- and post-test that provides a numeric description of trends, attitudes, or opinions of a population and focused on surveys and experiments (Creswell, 2014; Happner, Wampold, & Kivlighan, 2008a, 2008c). Quantitative measures were used to determine the effect of the expressive group counseling interventions. To increase the validity and reliability of this research, there are a couple of requirements including randomly selected participants and a control group (Creswell, 2014; Happner et al., 2008a, 2008c).

The research design in this study determined the relationships between acculturative stress and depressive symptoms in Korean immigrant women and evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. There were randomly assigned control and interventions groups. Data was collected and measured by the researcher to evaluate a change in pre- and post-questionnaires surveys and collect demographic information. The questionnaires were followed up using two scale-ranging surveys to examine acculturative stress and depressive symptoms among Korean immigrant women in the United States.

This study used a post-session evaluation to gather information regarding participants' experience with the expressive group counseling interventions. This post-session evaluation assessed which expressive group counseling interventions are more useful for Korean immigrant women in the United States. Data was analyzed by the researcher to determine different perceptions of participants receiving expressive group counseling interventions.

The category of the independent variable (IV) for this study is a total of four sessions in two-weeks of expressive group counseling interventions. The dependent variables (DVs) of this study are the participants' responses to the demographic questionnaire, the Acculturative Stress

Index (ASI), and the Center for Epidemiological Studies Depression (CES-D) scale, and the post-session survey.

### **Research Questions**

This research methodology is designed to determine: (1) the relationship between acculturative stress and depressive symptoms in Korean immigrant women and (2) the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms.

The research questions for this study are as follows:

- (1) Is acculturative stress positively related to depressive symptoms in Korean women who have immigrated to the United States and live in the southern or central region of Texas?
- (2) Does acculturative stress significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for depressive symptoms?
- (3) Do depressive symptoms significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for acculturative stress?

### **Participants**

Upon receiving approval from the Institutional Review Board (see Appendix A), this study used convenience sample method to recruit participants due to a difficulty in accessing the study population directly. The participants consisted of adult Korean immigrant women who: 1) were born in Korea; 2) lived in the southern and central region of Texas; 3) are at least 18 years old; 4) immigrated to the U.S. from Korea after their 16th birthday; 5) have lived in the United States more than six months; 6) are able to speak, read, and write Korean; 7) currently do not receive any therapeutic treatments, 8) have self-identified that they have experienced acculturative stress and depressive symptoms; and 9) voluntarily want to participate in this research.

According to Noh and Avison (1996) and Noh and Kaspar (2003), Koreans who immigrated before age 16 show substantially different adjustment experiences from those of older adult immigrants. This study excluded those who migrated to the United States before age 16 and include only those who migrated to the United States at the age of 16 or older. Additionally, the study excluded participants who had a history of substance abuse or severe cognitive impairment.

The researcher randomly assigned the participants to either a control group or an intervention group. Participants were chosen for the study based on their interest in the purpose of the study, availability to participate in the expressive therapy sessions, and willingness to commit to the time needed for full participation.

The participants for this study were recruited in various ways. Recruitment flyers were distributed at area Korean stores, area Korean restaurants, area Korean newspapers, and social media including Facebook and Korean community websites, and by obtaining cooperation from

Korean language schools, Korean churches, and Korean social clubs. The flyers were in both English and Korean versions (see Appendices B & C).

The researcher contacted the principals and directors of Korean language schools to request their possible cooperation in providing information about the study to the guardians of their students. The researcher, who is not a member of any local Korean churches or Korean social clubs, contacted Korean church pastors and leaders of social clubs to ask their cooperation in obtaining more participants for this study. The researcher explained the purpose of the study and methods involved to the pastors and leaders. During this time, the researcher explained the purpose, procedures, risks, and benefits of this study to the pastors and leaders to get permission for recruiting of participants and to ask for their cooperation. The researcher also shared information about how confidentiality would be maintained to the participants and the persons who assisted in recruiting participants.

When potential participants contacted the researcher indicating their interest in participating in the study, the researcher verified that they met participant requirements (e. g. born in Korea, are between the ages of 18 and older, immigrated to the U.S. from Korea on or after their 16 birthdays, etc.) and described brief introduction of the research, a description of the purpose, and significances and possible psychological risks of participations to the potential participants.

As a part of the overall recruitment and screening process, the researcher met potential participants individually or as a group to provide a brief introduction of the research, a description of the purpose of the study, and significance and possible psychological risks of participation in the study. Because of the challenge of finding qualified Korean counselors who are fluent in the Korean language, the researcher also served as the facilitator (counselor) for the expressive group counseling interventions in the study. The researcher/facilitator provided

additional details including the cost, limitation of confidentiality, risk and benefit of participants this study for the potential participants who need to make an informed decision whether they would join or not in this study.

The researcher screened potential participants regarding their interest in the purpose of study, availability to participate in the expressive therapy session, and willingness to commit to the time needed for full participations. Additionally, the researcher informed potential participants that some applicants would be not a good fit for the study purposes. The facilitator provided alternative resources or other recommendations to those did not meet the purpose of the study.

### **Power Analysis**

Power analysis was conducted using a G\*Power 3.1 software to determine the number of participants needed for the study. Power was estimated at .83 with a medium effect size of 0.5 and significant level of 0.05. An analysis determined that a minimum of 36 participants needed to be recruited for the study to detect an effect.

### **Location**

The locations for this research study took a place in local non-profit community agencies centers, local Korean community centers, and local Korean churches. The request letter for permission to use facilities (see Appendices D & E) was forwarded to the local community counseling centers, local Korean community centers, and a local Korean language schools when the research was conducted. For participants' convenience, the particular location was defined depending upon the specific group residence location. For the purpose of this research, facilities were chosen that had enough space to allow participants to perform the experiential activities included in the group counseling intervention.

### **Measuring Instruments**

The following self-report instruments used in this study were: a demographic questionnaire, the Acculturative Stress Index (Noh & Avison, 1996), the Center for Epidemiological Studies Depression scale (Radloff, 1977), and post-session survey. The following sections describe these instruments. For this study each question was initially asked in English and followed beneath by the same question asked in Korean.

#### **Demographic Questionnaire**

The demographic questionnaire is used to provide the researcher with information about each participant's age, level of education, marital status, employment status, household income, religion, length of time living in the United States, self-identified ethnicity, and ethnicities of friends. This demographic information was used to describe the participants and to clarify how representative the participants are of the general Korean immigrant population in south Texas. This information was not used as variables in the research questions (see Appendix F).

#### **Acculturative Stress**

Acculturative stress was measured using the Acculturative Stress Index (ASI; Noh & Avison, 1996). The level of acculturative stress was examined by analyzing two dependent variables: (a) experiencing difficulties and (b) specific circumstances increasing stress.

Participants completed the Acculturative Stress Index (ASI) to rate their experience difficulties.

Noh and Avison (1996) originally developed the ASI for the Korean Mental Health Study (KMHS) that was “a two-wave panel study of life strains and mental health problems among Korean immigrants in Toronto” (p. 196). This self-report measurement contains 31-items, each rated on a 4-point Likert-type scale. Although the ASI is designed to use in the assessment of the degree of difficulty in an individuals' adjustment to living in Toronto, the researcher believes that the same adjustment tasks apply to living in the United States (Park, 2007; Rhee, 2016). The



questionnaire was developed based on the literature describing the cultural and structural sources of stress that Korean immigrants face (Moon, 2011, p. 3). This instrument evaluates “chronic strains associated with adaption strains” (Noh & Avison, 1996, p. 198) in the following major areas: language barrier, homesickness, social isolation, social discrimination, sense of marginality, opportunity for occupational and financial mobility, and problems in the family. (Moon, 2011; Noh & Avison, 1996; Noh & Kaspar, 2003; Rhee, 2016). The participants rated their perceptions of each source of stress on a 4- point scale that includes 1 (never), 2 (sometimes), 3 (often), and 4 (very often). Scores for each item were equally weighted and summed to provide a total score; higher scores of ASI indicate high level of acculturative stress. The scale does not indicate the specific period of time over which participant experiences stressfulness since it measures chronic life stains that continue and bear over time.

According to Noh and Avison (1996), their study with Korean immigrants in Toronto had indicated that the ASI had adequate internal consistency, with the  $\alpha$  coefficients for seven subscales ranging from .77 to .89 and the  $\alpha$  coefficients for the total instrument being 0.91. Each question was initially asked in English and followed by the same question asked in Korean for this study. Cronbach's alpha for the ASI was 0.93(pre-test) and 0.94(post-test) in this study. The original creators of the scale, Noh and Avison (1996), translated the ASI into Korean (see Appendix G).

### **Depressive Symptoms**

Depressive symptoms were measured using the Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). Radloff (1977) developed the CES-D scale to evaluate depressive symptoms for the general community populations. Oh et al. (2002) considered this scale is “a psychometrically well-established instrument” (p. 516) and Park (2007) stated that it was one of the most commonly used instruments measuring current levels of

depressive symptoms. The CES\_D scale has been used with both clinical and general population (Radloff & Locke, 1986).

The CES-D is a self-report, 20-item scale that is used to assess frequency of depressive symptoms experienced during the past week (Radloff, 1977). According to Radloff (1977), the 20 items on the scale were initially taken from previously depression instruments such as Beck Depression Inventory and Minnesota Multiphasic Personality Inventory. The scale consists of items associated with four symptom clusters: depressed affect, positive affect, somatic and retarded activity, and interpersonal problems (Radloff, 1977). Statements related to positive affect include, "I felt that I was as good as other people", "I felt hopeful about the future", and "I enjoyed life". Statements related to depressed affect include, "I felt depressed," "I felt lonely," and "I had crying spells". Items linked to somatic and retarded symptoms relate to loss of appetite and disturbance of sleep. Items linked to interpersonal problems focus on difficulty while working with others.

Participants responded to each item using a 4-point Likert-type scale, with 0 indicating rarely or none of the time (less than 1 day), 1 indicating some or a little of the time (1-2 days), 2 indicating occasionally or a moderate amount of time (3-4 days), and 3 indicating most or all of the time (5-7 days). Positive items are reverse scored, and the total score for the CES-D is the sum of all items, yielding a total score range from 0 to 60. Higher scores indicate more frequent experiences of depressive symptoms.

According to Radloff (1977), the CES-D is reported to have high internal consistency reliability range from 0.85 in the general population to 0.90 in a psychiatric population. Additionally, it is reported good construct validity in subgroups (Hovey, 1999; Husaini, Neff, Harrington, Hughes, & Stone, 1980; Kelly, Kelly, Brown, & Kelly, 1999; Poresky, Clark, & Daniels, 2000; Pretorius, 1991). The CES-D scale has consistently demonstrated high reliability

and validity in cross-cultural and different ethnic populations research (Radloff, 1977) including Korean (Black, Markides, & Miller, 1998; Cheung & Bagley, 1998; Hurh & Kim, 1990; Iwata & Roberts, 1996; Jang, Kim, & Chiriboga, 2005; Kim et al., 2005; Mackinnon, McCallum, Andrews, & Anderson, 1998; Noh, Kaspar, Chen, 1998), Mexican (Black et al., 1998), Chinese (Cheung and Bagley, 1998; Li & Hicks, 2010), Japanese (Iwata and Roberts, 1996), and other Asian samples (Mackinnon et al., 1998).

This study used the Korean version of the CES-D, which was translated by Noh, Avison, and Kaspar (1992). The Korean version of the CES-D scale was used in many studies to measure depressive symptoms of Korean population and has shown satisfactory reliability and validity (e.g., Kim, Han, & Phillips, 2003; Noh, Avison, & Kasper, 1992; Noh et al., 1998; Oh et al., 2002). The reliability with the Korean population was reported as  $\alpha = 0.89$  (Noh et al., 1998). Cronbach's alpha for the CES-D was 0.93 (pre-test) and 0.95 (post-test) in this study. (see Appendix H).

### **Post-Session Survey**

The post-session survey is designed to understand the impact of particular intervention and effectiveness of group counseling setting among Korean immigrant women in the United States. The questionnaire was self-reported and measures participants' experiences with the program. The participants completed the questionnaire with Likert type scale.

The researcher developed the 9-question post-session survey to evaluate the impact of using expressive group counseling interventions (see Appendix I). This survey was used to collect information from participants in intervention group counseling regarding their experience in the expressive interventions in a group counseling. First 8-questions, in the form of Likert scale asks to assessed participants' preference of using expressive interventions in group counseling. The last question was an open-ended question including asking the participants to

provide detailed information or additional comments about their experience of using expressive interventions in the group counseling setting (see Appendix I).

### **Procedures**

The present research study investigated the effect of expressive group counseling interventions among Korean immigrant women either in the intervention group or in the control group. The requirements of group facilitator and specific needs of each group will be discussed below.

#### **Group Facilitator**

The group facilitator, also the researcher, is a licensed counselor and a registered play therapist with knowledge of group counseling. The group facilitator is trained in and continues to receive training in expressive therapy interventions. The facilitator of this group has experience leading groups and integrating both play therapy and expressive therapy interventions in group counseling. The group facilitator is professionally educated, trained, and experienced in the fields of trauma, multicultural counseling, and acculturation counseling. Additionally, the facilitator has experience working with individuals who struggle with depressive symptoms and acculturative stress. The facilitator has a professional and personal awareness of the difficulties and the psychological impact of the acculturation process on Korean immigrants and has demonstrated the ability to develop a strong therapeutic relationship with Korean clients. Furthermore, the group facilitator is fluent in both written and spoken Korean and has sound knowledge of Korean culture.

The facilitator of this group had an ethical responsibility to be aware of different roles and dynamics in group counseling (Thomas & Pender, 2008). According to American Counseling Association (2014), the facilitator must “protect clients from physical, emotional, or psychological trauma” (p. 6) in a group setting. The facilitator also must have knowledge of how

to professionally and ethically respond to the group members when problems or issues arise in the group (Thomas & Pender, 2008). Additionally, the facilitator must work to avoid any emotional, physical, or psychological, harm to group members (Corey, 2016; Thomas & Pender, 2008).

The facilitator preserves “awareness and sensitivity regarding the cultural meaning of confidentiality and privacy” (Thomas & Pender, 2008, p. 113). One of the main responsibilities of group leaders is to develop “empathy on both cognitive and affective levels” (Corey, 2016, p. 36) and to demonstrate this “competently and effectively with diverse group members” (Corey, 2016, p. 36). The facilitator of the group demonstrates multicultural competence within group members by recognizing the diversity and possible impact of participants’ experiences related to ethnicity, race, age, religion, spirituality, appearance, gender, sexual identity, ability/disability, language, norms, cultural value, and social economic status of the group participants (Corey, 2016; Singh, Merchant, Skudrzyk, & Ingene, 2012). It is important for the facilitator to respect cultural norms and values of the group members and to create a safe environment without racism or biases (Corey, 2016; Singh et al., 2012; Thomas & Pender, 2008).

### **Recruitment Procedure**

The researcher distributed and displayed recruitment flyers at area Korean stores, area Korean restaurants, area Korean newspapers, Korean language schools, Korean churches, Korean social clubs, and social media including Facebook and Korean community websites. The flyers were in both English and Korean (see Appendices B & C). Potential participants contacted the researcher, to obtain more detailed information about the study. The researcher provided additional details including the dates, general times (final times were dependent on random assignment to groups), and locations of the study meetings, the structure of the research, the potential risks and benefits of the research, and guideline for the potential participants so that the

potential participants can make an informed decision whether they would or would not join this study.

A screening process for determining potential members is highly recommended for group counseling (Corey, 2016; Rogers, 2011). The researcher screened potential participants regarding their interest in study, availability to participate, willingness to engage in the expressive activities, and readiness to commit to the time needed for full participation. This process provided an opportunity for the group facilitator to determine the potential participants who would be a good fit for this study and may potentially work well together. Any potential participants who had a history of substance abuse, severe cognitive impairment, or severe mental disorders such as schizophrenia were excluded from consideration for the study. Additionally, participants who currently were receiving any form of mental health counseling were excluded. The researcher obtained contact information from qualified participants so that she could give final times to the participants after a final roster of participants had been developed and group assignments have been made.

### **Group Assignment**

After obtaining a list of participants, the researcher randomly assigned the participants to either a control group or an intervention in group using the QuickCalcs application from GraphPad Software, which is available at <https://www.graphpad.com/quickcalcs/randomize1/>. QuickCalcs is a free resource for researchers and students that assigns participants to treatment groups. The researcher numbered each participant on the participant roster and divide the total number of participants by two to determine the number of participants desired for each of the two groups (treatment and control group). The researcher then entered into QuickCalcs the number of participants for each group in the *subjects* box, 2 in the *groups* box, and 1 in the *repeat* box. Participant numbers assigned to Group A was assigned to the intervention group, and

participant numbers assigned to group B was assigned to the control group. Participants in the intervention group received expressive group counseling interventions, while the participants in the control group received a placebo activity.

### **Confidentiality**

Maintaining confidentiality of information collected from the participants is important (Happner et al., 2008c). In order to protect this information, the researcher assigned each participant an identifying fruit or vegetable by placing a sticker by the participant's name on the participant roster. The researcher then placed identical stickers on pre- and post-survey packages that were given to the corresponding participants. The researcher protected the participant roster, which was the only research document containing participants' names or contact information, by storing the roster in a locked cabinet in a locked room in the researcher's home. The researcher brought this roster to the initial and final meetings with participants in order to give participants the correct pre- and post-survey packages. While in transit to these meetings, the researcher stored the roster in a locked box in the locked trunk of the automobile. After each data collection, the completed survey packages were stored in a locked cabinet in a locked room in the researcher's home. This locked cabinet was separated from the cabinet where the participant roster was stored. Other than the researcher and the researcher's dissertation advisor, no one was allowed access to the participant roster or survey packages. Although the survey packages would be kept for at least five years after the conclusion of the study, the researcher would safeguard the participant roster by shredding it after the post-test surveys have been completed.

### **Control Group**

The control group met twice with the researcher. At the first meeting, control group participants were asked to read the information sheet (see Appendices J & K) and ask any questions they wanted about the study. For linguistic equivalence of the Korean information

sheet, two bilinguals were employed to translate and back translate the sheet, one translating from English to Korean, the second translating back from Korean to English (see Appendix L). The researcher then reviewed to check accuracy between two versions. They then were asked to give verbal consent to participate in the study. After verbal consent was obtained, they were given pre-test surveys to complete. These surveys include the demographic questionnaire, the Acculturative Stress Index (ASI), and the Center for Epidemiological Studies Depression (CES-D) scale.

The researcher then gave each control group participant a package that included four pages of printed pictures, some coloring pencils, and instructions to color each of the pictures on specific days during the next two weeks. These days corresponded to the days that the intervention group will receive group counseling. The package also contained instructions to return in three weeks for debriefing and to complete post-test surveys. The control group received the coloring activity as a placebo. Control group participants might have believed that they were receiving an expressive intervention, even though the coloring activity was not intended to be therapeutic. The researcher expected that this first meeting would require approximately 30 minutes of the participants' time.

At the next meeting three weeks later, participants in the control group were asked to complete post-test surveys including the Acculturative Stress Index (ASI) and the Center for Epidemiological Studies Depression (CES-D) scale. The researcher debriefed the control group participants by informing them that the coloring activity was not a therapeutic treatment, and was designed to have no real effect. Additionally, the researcher offered the same interventions that the intervention group received to the participants in the control group if the treatment was determined to be effective. The researcher took names and contact information of control group participants who were interested in receiving the expressive interventions in group counseling



treatment. The researcher stored this contact information in her clinical files and contacted these control group participants following the data analysis in order to arrange the next expressive intervention counseling group or to inform these participants that the expressive intervention counseling group intervention was determined to be ineffective. Before the control group participants left the post-test meeting, the researcher gave each participant a \$10 gift card to HEB Grocery Store.

### **Intervention Group**

The intervention group met twice weekly for two weeks for a total of four sessions of expressive interventions and once following the final counseling session to complete post-test surveys. All counseling sessions were conducted in Korean, but the group facilitator encouraged participants to share in the language of their choosing. At the first meeting, participants in the intervention group were asked to read the information sheet (see Appendices J & K) and asked any questions they wanted about the study. They then were asked to give verbal consent to participate in the study. After verbal consent was obtained, they were given pre-test surveys to complete. These surveys include the demographic questionnaire, the Acculturative Stress Index (ASI), and the Center for Epidemiological Studies Depression (CES-D) scale. The researcher expected that the research consent process and completing the pre-test surveys would require approximately 30 minutes.

Following the completion of the pre-test surveys, the first session of expressive interventions in group counseling began. The second session was conducted later in the week, and the third and fourth sessions were conducted the following week. Each of the counseling sessions lasted approximately one and half hours. The expressive group counseling interventions that were used, included painting, drawing, drumming, dancing, writing, meditation, movement,

and sandtray to express themselves. The participants were encouraged to share and discuss their experience in each session.

A week after the final session, the intervention group met a final time, during which post-survey packages were completed by the participants, and the researcher gave each participant a \$10 gift card to HEB Grocery Store.

**Group purpose and goals.** The primary purpose of this group is to support the participants in reducing their psychological distress and developing alternative coping strategies through engaging in creative and expressive arts interventions in group counseling. The group facilitator (also the researcher) intended to provide a safe and supportive environment for the participants to express their personal experiences, such as how they felt and what they went through while living in the United States. Additionally, this group was to offer a nonjudgmental and non-threatening environment for the group participants to share their concerns related to psychological distress, including depressive symptoms and acculturation stress related to the process of role changes, language barriers, homesickness, social isolation, family conflicts, and social discrimination.

The goals of the group were for the participants (1) to create empathetic and supportive relationships among individuals in group; (2) to gain empathy and understanding for each members' unique experiences with distress; (3) to learn to increase self-awareness, self-actualization, self-expression, self-directed growth, and personal healing; (4) to learn ways of expressing feeling and thoughts without any judgment; (5) to recognize both their strengths and weaknesses; (6) to increase confidence in integration within the main society in the U.S.; and (7) to gain healthy and effective coping strategies to decrease acculturative stress and depressive symptoms.

Group members naturally supported each other and received the benefit from each one while working with others in the group (Corey, 2016; Rogers, 2011). While listening to the other members' stories or experiences, each individual understood that she was not alone in dealing with her difficulties and struggles. The group members provided strong support to each other. Participants also developed positive friendships by working together with others to overcome issues and provided support and resources to each other. The members learned how to connect with others and help each other move in the direction of healing.

**Theoretical orientation and sessions.** The theoretical model that was used to run the group was Gestalt therapy (Oaklander, 2003) integrated with expressive interventions (Malchiodi, 2005). The group using expressive group counseling interventions included painting a mask, sandtray creation, writing, meditation, coloring mandalas, drumming, dancing, and drawing while using Gestalt therapy as an approach to work with Korean immigrant women.

**Session one: Just a feeling: Beginning your journey.** Prior to the first session, the group facilitator had set up the art supplies (e.g. masks, crayon, acrylic paint, painting brushes, color papers, construction paper, scissors, gules, glue guns, glue gun sticks, glitter, and beads) and prepared Korean traditional and classical music, *Gugak*, to play while participants were decorating their masks. The masks, which were purchased in Korea, represent Korean cultures.

After the participants complete the research study consent process and the pre-test surveys; the counseling segment of the first session began with the group facilitator welcoming the members to the group and conducting the group counseling consent process, which complied with Texas counseling regulations (2017) and the *American Counseling Association Code of Ethics* (2014). A copy of the associated group counseling informed consent document can be found in Appendices M and N. Linguistic equivalence of Korean group counseling informed consent document was examined by using the translation and back translation method (see

Appendix O). Participants will receive a copy of the group counseling informed consent document and sign a copy that will be placed in the client's clinical records. This document is not part of the research documents; it is handled according to TX regulations for counseling clinical records.) The group facilitator reviewed the purpose, structure, expectations, guidelines, agreements, and rules of the group with the group members. The group discussed the roles and responsibilities of the facilitator and group members, including the maintenance of confidentiality.

The group facilitator introduced the expressive interventions and the value of expression as an adult. The facilitator also explained that the group would focus on each member's creative and expressive healing process, not on the artwork product or becoming an artist (Rogers, 2011). The group facilitator spent time answering any questions regarding the group, and members introduced themselves with their names and personal reasons for wanting to participate in the group. The group facilitator encouraged the group members to engage naturally with each other in the group (Corey, 2016).

Brief mindfulness meditation practiced helping group members to relax their body and mind before beginning the actual session. The group continued with a discussion that focused on identifying their feelings and sharing how these feelings would look if they were represented by a mask. The group members were invited to participate in an exercise named "Just a Feeling: Beginning Your Journey." This exercise is designed to help the group members become better acquainted with their emotions and express their emotions through creating their own masks. This activity was intended to lead participants to become determined and aware of their feelings in the present moment (Corey, 2013b). Additionally, participants focused on increasing awareness of self, taking ownership of personal experiences, and increasing awareness of all senses (Corey, 2016; Rogers, 2011).

The group participants were also asked to choose and decorate a mask using art supplies to express how they were feeling in the present moment regarding living in the United States. The group members were given up to 40 minutes to decorate their masks. The group facilitator then asked the participants to write a poem or letter reflecting their emotions, experiences, changes, or thoughts while creating their masks. Additionally, the facilitator encouraged the participants to share their masks and their experiences while decorating the masks with the group. The facilitator informed the participants that sharing their feelings and experiences was not mandatory but could be helpful, as sharing is another form of expression.

This first session is designed to help the group members become more aware of their feelings and learn how to use art as a coping skill for expressing their feelings. Following the members' sharing, the group facilitator asked the group members how they could use art outside of the group sessions to clarify and express emotions. Using art outside of the group would be encouraged. The group facilitator then guided the group into the session closure with brief mindfulness meditation that helped group members to decrease emotional reactivity and improve ability to regulate their behaviors (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). The facilitator asked the group members to leave their masks in the room so that they could be used again in a later session (See Appendix P).

**Session two: The simple path of your journey.** Prior to this session, the group facilitator set up the sandtrays and miniatures in the room (Homeyer & Sweeney, 2011). Because of the limited space in a group counseling setting, the group members used small containers as individual sandtrays. The individual sandtrays that were used were rectangular clear plastic boxes with blue lids. The boxes were 12 by 8.5 inches and 3 inches deep, and the blue lids were placed under the boxes to create a blue colored bottom. Each participant in the group was given

her own sandtray. The group facilitator made sure that sand was smooth in all the group members' sandtrays.

Miniatures were set up in one central location that all group members could easily access. The miniatures included a variety of figures representing humans, animals, buildings, transportation methods, trees, flowers, fences, gates, signs, natural items, fantasy icons, spiritual symbols, household items, medical items, drug- and alcohol-related items, and cultural images, especially Korean and Asian cultural images. The room was set up so that there would be adequate space for the group members to easily move around to select miniatures. The facilitator placed a sandtray, several sheets of paper, and a pencil on a table for each participant prior to the beginning of the session. In final preparation for the group session, the facilitator prepared Korean traditional and classic music, *Gugak*, to play while the group members were creating their worlds in sand.

Brief mindfulness meditation practiced helping group members to relax their body and mind before beginning the actual session. The second session started with a brief reminder of the purpose, structure, expectations, guidelines, agreements, and rules of the group. The group members were invited to share anything that had come up since the previous session, including their experience of the prior session's mask creation, feelings, thoughts, beliefs, difficulties, or challenges and the use of art outside of the group setting (Rogers, 1993, 2011). The group facilitator encouraged the group members to believe in themselves and their unique process to increase their inner child (Corey, 2016; Rogers, 1993, 2011).

The theme for this session was "The Simple Path of Your Journey" and included a sandtray activity. In this session, the facilitator introduced the sandtray and provided basic sandtray instructions to the group members (Homeyer & Sweeney, 2011). The group members were invited to create the world in which they wanted to live using the sand and miniatures and

to write about their experiences creating their worlds. Group members were given at least 30 minutes to build their worlds. The group facilitator played Korean traditional and classical music in the background during this activity. As group members completed their worlds and writing, the facilitator asked the group members to create a title for their worlds.

Although sharing was voluntary, the group facilitator encouraged participants in the intervention group to share their worlds, their titles of their worlds, and their experiences creating the worlds in which they wanted to live. The researcher informed the participants that sharing their feelings and experience is not required but doing so could help them and other group members in their healing processes. Group members were reminded that they should respond to each other's worlds and statements in nonjudgmental and non-threatening ways to support each other's concerns, thoughts, feelings, and experiences. The facilitator encouraged the group members to move around the room to more fully share their worlds with each other. The group facilitator explained that the sandtray activity may stimulate various emotions and thoughts. The group facilitator guided the group into the session closure with brief mindfulness meditation that helped group members to decrease emotional reactivity and improve ability to regulate their behaviors (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). The facilitator ended the session by suggesting that participants write about these emotions and thoughts during the next few days as they reflected on this activity and bring those writings to the next group session (see appendix P).

**Session three: In peace with your journey.** Prior to the third session, the group facilitator had set up the room. All tables and most chairs were removed from the room to provide enough space for members to sit and lay down before the session started, if they chose. The group facilitator prepared yoga mats, blankets, and cushions to provide a safe environment for the group members.

The group facilitator checked with the group members' emotional and mental stability after experiencing the last two sessions and briefly reviewed the purpose, structure, expectations, guidelines, agreements and rules of the group. Again, the facilitator informed the group members not to hesitate to contact her if facilitator if they experienced any emotional and psychological difficulty.

The theme for the third session was "In a Peace with Your Journey," which focused on self-awareness. This session used two mindfulness activities as expressive intervention. The facilitator suggested that group members work barefoot to improve the experiential quality of the activities (Pearson & Wilson, 2009).

The group facilitator instructed the group members to begin to move around the room and focus on their whole bodies. For example, the facilitator invited the group members to relax their bodies and drop the tension in their necks and shoulders (Pearson & Wilson, 2009). Next, the group facilitator asked the group to be aware of their whole body, where they feel pain, the speed of their hearts, and any feelings of heaviness (Pearson & Wilson, 2009). After the group became aware of their bodies, the group members were invited to sit or lay down on the floor or in a chair if needed for comfort or accessibility (Pearson & Wilson, 2009).

The facilitator conducted a guided meditation for the group, instructing the members to close their eyes and take some deep breaths (Pearson & Wilson, 2009). Next, the facilitator guided the group members to imagine themselves in a calm, peaceful, and relaxed place while paying attention to their breathing. This activity helped the group members to relax and focus on mindfulness. The facilitator invited the group members to create their own stories in their minds with peaceful images that helped them to relax. This took approximately 30 minutes.

After the meditation, the group members participated in creating mandalas that were aligned with how they felt at that moment. The group facilitator explained the mandala project



and remind the participants that the purpose of this activity was not to create an artistic product but to express their inner state. Participants were given drawing paper, various sizes of bowls that they could use to help them draw one or more circles on the paper, and art supplies (e.g. color pencils, markers, and crayons). The facilitator showed the group members a couple of mandalas, which were created by the facilitator to help the participants to understand this project. Again, the facilitator encouraged the group members to be nonjudgmental about their creations.

The group facilitator asked to the participants to simply start with a circle and then fill in the circle with anything what they wanted, such as patterns, colors, symbols, animals, or even other circles. While creating the mandalas, the group was encouraged not to talk and to listen to the Korean traditional relaxation music, which might help to calm their minds. The facilitator prompted the participants to focus on how they felt today and as they completed their mandalas and to write a poem or letter reflecting on their emotions, experiences, changes, or thoughts while creating mandalas. This activity took approximately 30 minutes. The facilitator encouraged the participants to share their experiences in movement, meditation, and mandala creation with the group. The facilitator reminded the participants that sharing was not mandatory but sharing could be helpful to themselves and the other group members. The group facilitator guided the group into the session closure with brief mindfulness meditation that helped group members to decrease emotional reactivity and improve ability to regulate their behaviors (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). The facilitator closed the session and encourage group members to practice some of the activities from the day's session at home and reflect on any changes in their thoughts and emotions (see appendix P).

**Session four: Healing and celebrating in your journey.** Prior to the fourth session, the group facilitator had set up the room. All tables and most chairs were removed from the room to provide enough space for members to sit and lie down before the session started, if they chose.

The group facilitator prepared yoga mats, blankets, and cushions to provide a safe environment for the group members.

The group facilitator placed all art supplies, musical equipment, and masks from session one to the side in the room. One of the unique pieces of equipment for this session was a traditional Korean hand drum, a *sogo*. A *sogo* is a small drum with thin hides on the two sides of a thin wooden body (Howard, 1995) that comes with a short stick used to hit the hides and body. The group facilitator prepared to play Korean traditional music including slow, medium, and fast tempos. The facilitator also prepared light drinks and snacks that the group members can enjoy towards the end of the session.

Brief mindfulness meditation practiced to help group members to relax their body and mind before beginning the actual session. The group facilitator started the session with a brief reminder of the purpose, structure, expectations, guidelines, agreements, and rules of the group. The group members were invited to share anything that had surfaced over the past week, including their experience of the prior week, feelings, thoughts, beliefs, difficulties, or challenges (Rogers, 1993, 2011). Additionally, the group facilitator reminded the group that this session was going to be last counseling session for the group but that the members were to meet one additional time to complete some surveys for the research study.

The theme for the fourth session was “Healing and Celebrating in Your Journey,” which focused on the present and understanding what is really happening at the time. The group facilitator placed emphasis on the group members becoming more aware of themselves and taking more responsibility for their thoughts and feelings (Corey, 2016; Rogers, 1993, 2011). The facilitator also emphasized that each group member had worked hard on herself to reconnect with her inner self through the past three sessions. This session is a celebration of all of the

efforts that were made during the group experience for changing and healing as they continued on their journey.

This session's expressive intervention combined drumming and dancing. Celebrating in the Korean culture is strongly associated with music and dance (Lee, 2011). The facilitator briefly introduced the *sogo* drumming dance, assuming many group participants already knew the *sogo* drumming dance. The group facilitator demonstrated basic *sogo* drumming beat and rhythms. The facilitator also demonstrated basic *sogo* movement as a dance. The group was invited to follow the facilitator's performance until the group members felt comfortable moving their bodies or dancing in front of each other. Encouragement and support by the group facilitator and members increased the positive outcome. The facilitator normalized any shyness, embarrassment, or emotional discomfort the group members may felt related to dancing in front of other people. If a group member felt uncomfortable, the group facilitator suggested wearing the mask that the group member created during the first session. After the group members became more comfortable with this activity, the facilitator suggested that the group members play the drum with whatever beat they wanted and dance however they wanted to move. The facilitator suggested that group members take turns drumming and dancing for the whole group, while the other group members followed their lead. This activity took approximately 30 minutes.

The group facilitator then offered the group members about 10 minutes to calm down and relax and refresh themselves with light drinks and snacks. The facilitator then asked the group members to sit in a circle. After every group member was seated, the group facilitator invited the group members to individually draw a tree with acrylic paints on an 8-by-10-inch canvas panel that represented who they are now and when they completed the painting, to write a statement, a poem, or letter describing their healing journey on the back of the panel. The facilitator then gave

the group members approximately 30 minutes for this activity. The group facilitator played Korean traditional and classical music while the participants paint and write.

The facilitator suggested to the participants in the intervention group that they could write sentences or a letter about how they wanted to deal with stress while living in the United States in the future outside of this group. The intervention group participants were invited to share their trees and experiences in playing drum and dancing in this session activities and their tree. Again, the researcher informed to the participants sharing their feeling and experience is not mandatory or demanding for this group, but a member's sharing could be helpful other group members to facilitate the healing process. This group offered the nonjudgmental and non-threatening environment for the group participants to share their concerns, thoughts, feelings, and experience.

The group facilitator guided the group into the session closure with brief mindfulness meditation that helped group members to decrease emotional reactivity and improve ability to regulate their behaviors (Corey, 2013b; Levine, 2012; Yontef & Jacobs, 2010). The group began to close the session and the group facilitator offered the group members briefly to go around and share their experience with other group members (see appendix P).

**Group termination and following-up session.** The intervention group participants gathered together the following week after the fourth session. The researcher asked the participants in the intervention group to complete the post-test surveys. The post-session survey was administered to all participants in the intervention group in this session too.

In this session, there needed to devote some time to discuss termination. Termination can present various negative feelings such as losing support, feeling alone, or anxiety. According to Corey, Corey, Callanan, and Russell (2015), individuals may experience various feelings including abandonment, the feeling of being deserted, loss, fear, and anxiety when they face a

transition or an ending in their life. Termination is the final stage of the counseling process, but it could be a new stage for the individuals.

For the complex mixed emotions, the researcher, as a group facilitator, needed to prepare the group for termination (Corey, 2016; Corey et al., 2015). The group facilitator discussed and explored the possible and potential issues of termination. The facilitator also strongly encouraged and reminded the group members that they had the ability to cope with the present negative issues and feelings in working with the activities that they experienced in the group. At the end of session, the facilitator reminded the group not to hesitate to contact the group facilitator if they experienced any emotional and/or psychological difficulty in the future. Additionally, the group facilitator strongly encouraged the group members to practice what they learned in the group and to include it in their lives. They were also to trust themselves (see Appendix P).

### **Statistics**

Data collected from the survey instruments were the demographic questionnaire, Acculturative Stress Index (ASI; Noh & Avison, 1996), and Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). The data were entered into SPSS, one of the most widely used software (Scott, 2014), for quantitative data analysis. Data were screened and cleaned up for any data that were missing from the dependent measures before running the analysis.

Descriptive statistics (e.g., means, standard deviations, frequencies, and percentages) were used to measure demographic information trends from the pre-treatment questionnaire, such as age, level of education, marital status, occupation, employment status, and socioeconomic status.

### **Research Question 1**

To address the first research question, we conducted Pearson Correlation coefficient ( $r$ ). The purpose of Pearson Correlation coefficient ( $r$ ) is to examine the strength of relationships between two variables (Meyers, Gamst, & Guarino, 2006). Using the data from pre-tests scores of Acculturative Stress Index (ASI; Noh & Avison, 1996) and Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977), we calculated the means and standard deviations to understand the relation between acculturative stress and depression symptoms. If the value is between 0.50 and 1, then it indicates a strong correlation between two variables. When the coefficient is significantly different from zero, then we conducted t-test to compare groups (control and comparison). In addition, missing or incomplete responses were considered as missing data and excluded from analysis, and raw scores were used.

### **Research Questions 2 and 3**

To address the second and third research questions, we conducted Analysis of covariance (ANCOVA). ANCOVA is a combination of regression and analysis of variance (ANOVA) which allows researchers to examine if the group means differ after the influence of another variable (e.g., intervention) on these scores has been compared across groups (Rutherford, 2011). According to Green and Salkind (2014), ANCOVA could be referred to data in which “(1) all cases are measured initially on a pre-test, (2) cases are randomly assigned to different groups, (3) groups receive different treatments, and (4) all cases subsequently are measured on a post-test” (p. 190).

Research question 2 was examined through an ANCOVA to determine post-test differences in Acculturative Stress Index (ASI) scores between the intervention and control groups, after controlling for ASI pre-test scores. Research question 3 was evaluated through an ANCOVA to assess post-test differences in the Center for Epidemiological Studies Depression

(CES-D) scores between the intervention and control groups, after controlling for CES-D pre-test scores.

## CHAPTER IV:

### RESULTS

This chapter describes the data analyses that were used to evaluate the relationship between acculturative stress and depressive symptoms in Korean immigrant women and to evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. Statistical analyses to examine each research question were conducted using SPSS 24.0. First, the participants' demographic characteristics were presented. Second, the Pearson Correlation coefficient ( $r$ ) test was used to determine the relationship between acculturative stress and depressive symptoms in Korean immigrant women. Third, the analysis of covariance (ANCOVA) was applied to test the difference of mean acculturative stress and depressive symptoms scores between intervention and control groups after the use of expressive group counseling interventions. Lastly, the results of the intervention group's post-session survey were presented.

#### **Descriptive Statistics for Demographic Characteristics**

A total of 79 Korean immigrant women who were referred were interviewed and considered for participation in the present study. There was a dropout rate of 26.58 % (21 participants). In the treatment group, three withdrew after the first session, six withdrew after third sessions, and two withdrew after the last session. In the control group, 10 withdrew after completing the pre-test instruments. A total of 58 participants (73.42%) completed the study and were included in the final analysis. Of the 58 participants, 20.69% ( $n = 12$ ) lived in central Texas and 79.31% ( $n = 46$ ) lived in South Texas. For the purpose of the study, participants were randomly assigned either to the intervention group ( $n = 29$ ) or a control group ( $n = 29$ ). A total of 29 (50%) participants in the intervention group attended four sessions of expressive group



counseling interventions and a total of 29 participants in the control group received the coloring activity as a placebo.

The ages of the participants ( $N = 58$ ) ranged from 27 to 74 years with a mean age of 48 years ( $SD = 11.972$ ). The mean age of participants for intervention group was 49.83 years ( $SD = 13.034$ ) and 46.17 years ( $SD = 12.148$ ) for the control group. Participants reported the length of living in the United States as between two and 48 years (median = 20.22 years,  $SD = 11.717$ ). An average length of residence in the United States for the intervention group was 22.31 years ( $SD = 11.835$ ) and 18.14 years ( $SD = 14.027$ ) for the control group. Within the intervention group, five (17.9%) reported living in the U.S. less than 10 years, eight (28.6%) reported living here from 10–20 years, six (21.4%) reported living here from 21–30 years, and nine (32.1%) reported living here from 30–39 years. Twelve participants (40%) in the control group reported living in the U.S. less than 10 years, nine (30%) reported from 10–20 years, and nine participants (30.1%) reported living in the U.S. more than 21 years. A majority of the participants ( $n = 35$ , 60.3%) identified themselves as Korean, while 12 (20.7%) considered themselves as half Korean and half American, eight (13.8%) as mostly Korean, and three (5.2%) reported as mostly American. In addition, 36 participants (62.1%) reported their friends as mostly Korean with a few American or others, and only three (5.2%) reported having friends who were mostly American or others and a few Korean.

Furthermore, 44 (75.9%) reported being married or having a domestic partnership, and 31 (53.4%) reported having children in their household. A majority of participants ( $n = 45$ , 77.6%) identified themselves as Protestant, eight (13.8%) reported as Catholic, and five (8.6%) identified as other. Twenty-one (36.3%) survey respondents indicated that they have at least a bachelor's degree and 22 (37.9%) reported that have at least a GED or high school diploma. Additionally, 28 (48.3%) respondents reported working for wages or being self-employed. More than half of

the respondents reported communicating well in English skills for speaking ( $n = 33, 56.9\%$ ), writing ( $n = 30, 51.7\%$ ), reading ( $n = 37, 63.8\%$ ), and listening ( $n = 34, 58.6\%$ ). See Table 1 for more detailed information about participant demographics.

**Table 1***General Demographic Information of Participants*

		Total ( $N=58$ )	Control ( $n = 29$ )	Intervention ( $n = 29$ )
		$n$ (%)	$n$ (%)	$n$ (%)
Age	20-29	1 (1.7)	1 (3.4)	0
	30-39	17 (29.3)	7 (24.1)	10 (34.5)
	40-49	12 (20.7)	10 (34.5)	2 (6.9)
	50-59	16 (27.6)	6 (20.7)	10 (34.5)
	60-69	11 (19.0)	4 (13.8)	7 (24.1)
	70+	1 (1.7)	1 (3.4)	0
Years lived in U.S.	<10 years	17 (29.3)	12 (40.0)	5 (17.9)
	10 - 20 years	17 (29.3)	9 (30.0)	8 (28.6)
	21 - 30 years	8 (13.8)	2 (6.7)	6 (21.4)
	30 - 39 years	14 (24.1)	5 (16.7)	9 (32.1)
	40+ years	2 (3.4)	2 (6.7)	0
Marital Status	Single, never married	5 (8.6)	4 (13.8)	1 (3.4)
	Married or Domestic Partnership	44 (75.9)	20 (69.0)	24 (82.8)
Marital Status	Widowed	4 (6.9)	2 (6.9)	2 (6.9)
	Divorced or separated	5 (8.6)	3 (10.3)	2 (6.9)

		Total ( <i>N</i> =58)	Control ( <i>n</i> = 29)	Intervention ( <i>n</i> = 29)
		<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Children in household	Yes	31 (53.4)	15 (51.7)	16 (55.2)
	No	27 (46.6)	14 (48.3)	13 (44.8)
Lived with U.S citizen as a partner	Yes	35 (60.3)	10 (34.5)	25 (86.2)
	No	23 (39.7)	19 (65.5)	4 (13.8)
Religion	Protestant	45 (77.6)	18 (62.1)	27 (93.1)
	Catholic	8 (13.8)	7 (24.1)	1 (3.4)
	Other	5 (8.6)	4 (13.8)	1 (3.4)
Highest education	Elementary school	3 (5.2)	1 (3.4)	2 (6.9)
	Middle school	3 (5.2)	1 (3.4)	2 (6.9)
	High School	12 (20.7)	6 (20.7)	6 (20.7)
	Some college credit, no degree	9 (15.5)	3 (10.3)	6 (20.7)
	Bachelor's degree	15 (25.9)	8 (27.6)	7 (24.1)
	Master's degree	3 (5.2)	8 (27.6)	4 (13.8)
	Doctorate or professional degree	3 (5.2)	2 (6.9)	1 (3.4)
	GEO or other	1 (1.7)	0	1 (3.4)
Employment status	Employed for wages	21 (36.2)	14 (48.3)	7 (24.1)
	Self-employed	7 (12.1)	3 (10.3)	4 (13.8)
Employment status	Out of work and looking for work	5 (8.6)	3 (10.3)	2 (6.9)
	Out of work but not currently looking for work	8 (13.8)	4 (13.8)	4 (13.8)

		Total (N=58)	Control (n = 29)	Intervention (n = 29)
		<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
	A housewife, not looking for work	7 (12.1)	2 (6.9)	5 (17.2)
	Student	7 (12.1)	3 (10.3)	4 (13.8)
	Retired	3 (5.2)	0	3 (10.3)
Proficiency in English skills - Speaking	Not at all	3 (5.2)	2 (6.9)	1 (3.4)
	Not well	15 (25.9)	7 (24.1)	8 (27.6)
	Well	33 (56.9)	15 (51.7)	18 (62.1)
	Very well	7 (12.1)	5 (17.2)	2 (6.9)
Proficiency in English skills - Writing	Not at all	3 (5.2)	2 (6.9)	1 (3.4)
	Not well	20 (34.5)	9 (31.0)	11 (27.9)
	Well	30 (51.7)	15 (51.7)	15 (51.7)
	Very well	5 (8.6)	3 (10.3)	2 (6.9)
Proficiency in English skills - Reading	Not at all	4 (6.9)	3 (10.3)	1 (3.4)
	Not well	11 (19.0)	5 (17.2)	6 (20.7)
	Well	37 (63.8)	17 (58.6)	20 (69.0)
	Very well	6 (10.3)	4 (13.8)	2 (6.9)
Proficiency in English skills - Listening	Not at all	4 (6.9)	3 (10.3)	10 (35.7)
	Not well	12 (20.7)	6 (20.7)	6 (20.7)
	Well	34 (58.6)	15 (51.7)	19 (65.5)
	Very well	8 (13.8)	5 (17.2)	3 (10.3)

Ethnic Identify	I'm Korean	35 (60.3)	22 (75.9)	13 (44.8)
	I'm mostly Korean	8 (13.8)	2 (6.9)	6 (20.7)
	I'm half Korean, half American	12 (20.7)	3 (10.3)	9 (31.0)
	I'm mostly American	3 (5.2)	2 (6.9)	1 (3.4)
Friends' ethnic identity	Only Korean	11 (19.0)	6 (20.7)	5 (17.9)
	Mostly Korean and a few American or other	36 (62.1)	15 (51.7)	21 (72.4)
	Half Korean and half American or other	8 (13.8)	6 (20.7)	2 (6.9)
	Mostly American or other and a few Korean	3 (5.2)	2 (6.9)	1 (3.4)

### Results by Research Question

Each research question was reviewed and statistically analyzed in the following section.

#### Research Question 1

Is acculturative stress positively related to depressive symptoms in Korean women who have immigrated to the United States and live in the southern or central region of Texas?

To answer the first research question regarding the relationship between acculturative stress and depressive symptoms in Korean women who have immigrated to the United States and live in the southern or central region of Texas, a Pearson Correlation coefficient ( $r$ ) was run using pre-test data. The Pearson Correlation coefficient ( $r$ ) test examines the strength and direction of the relationships between two variables (Meyers et al., 2006), in which a correlation between 0.50 and 1 indicates a strong relationship between the two variables and a correlation of zero indicates no relationship between the variables.

The relationship among the acculturative stress and depressive symptoms in Korean women who have immigrated to the United States and live in the southern or central region of Texas, pre-test of the Acculturative Stress Index (ASI) and the Center for Epidemiological Studies Depression (CES-D) scale scores were examined using Pearson Correlations. The pre-test of Acculturative Stress Index (ASI) and the Center for Epidemiological Studies Depression (CES-D) scale scores were analyzed across each participant to determine whether the Acculturative Stress Index (ASI) scores correlated with the Center for Epidemiological Studies Depression (CES-D) scale scores. The relationship of acculturative stress and depressive symptoms in Korean immigrant women was significant ( $p < 0.001(2\text{-tailed})$ ), and acculturative stress correlated strongly with depressive symptoms in Korean immigrant women (pre-test:  $r(58) = .603$ ). See Table 2 for the means and standard deviations to understand the relation between acculturative stress and depression symptoms.

**Table 2**

*Mean Scores of Pre-Tests of Acculturative Stress and Depression (N = 58)*

	<i>M</i>	<i>SD</i>
Pre-Test of Acculturative Stress Index (ASI)	55.431	16.855
Pre-Test of Center for Epidemiological Studies Depression (CES-D) scale	17.603	11.262

**Research Question 2**

Does acculturative stress significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for depressive symptoms?

To answer the second research question regarding the effect of the expressive group counseling interventions on acculturative stress in the designated Korean women, a one-way analysis of covariance (ANCOVA) was conducted to determine the effect of the expressive-group counseling interventions (IV) on the women's acculturative stress (DV).

The dependent variable was the post-test of acculturative stress and the covariates was pre-test of acculturative stress. A preliminary analysis evaluating the homogeneity-of-slopes assumption indicated that the relationship between the covariate (the pre-test of acculturative stress) and the dependent variable (the post-test of acculturative stress) did not differ significantly as a function of the independent variable,  $F(1, 54) = 0.076$ ,  $MSE = 144.61$ ,  $p = 0.783$ . The results of the ANCOVA indicated no statistically significant difference on testing the acculturative stress between the intervention and control groups,  $F(1,55) = 0.063$ ,  $MSE = 142.18$ ,  $p = 0.802$ . The mean of the acculturative stress for both the intervention and control groups had increased on the post-test. The control group had the higher adjusted mean ( $M = 57$ ) than the intervention group adjusted mean ( $M = 56$ ), which falls below the midpoint of the scale. See Tables 3 to 5 for results of ANCOVAs.

**Table 3**

*Descriptive Statistics on Acculturative Stress Pre-Test*

Group	<i>M</i>	<i>SD</i>	<i>n</i>
Intervention group	54.276	16.384	29
Control group	56.586	17.525	29
Total	55.431	16.855	58

**Table 4***Descriptive Statistics on Acculturative Stress Post-Ttest*

Group	<i>M</i>	<i>SD</i>	<i>n</i>
Intervention group	55.103	15.108	29
Control group	57.724	20.312	29
Total	56.413	17.791	58

**Table 5***ANCOVA Test of Acculturative Stress*

Source	Sum of squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
Pres-test	10122.383	1	10122.383	71.192	.000
Groups	8.887	1	8.997	.063	.802
Error	7820.100	55	142.184		

**Research Question 3**

Do depressive symptoms significantly decrease more for Korean women who immigrated to the United States, currently live in southern or central region of Texas, and participate in expressive group counseling interventions than for Korean women who immigrated to the United States, currently live in south or central Texas, and do not participate in expressive group counseling intervention, controlling for acculturative stress?

To answer the third research question regarding the effect of the expressive group counseling interventions on depressive symptoms in the Korean women, a one-way analysis of covariance (ANCOVA) was conducted to determine the effect of the expressive group counseling interventions (IV) on the Korean immigrant women's depressive symptoms (DV). The post-test of depressive symptoms was the dependent variable, and the pre-test of depressive



symptoms was the covariant. Homogeneity of variances was checked using Levene's Test with SPSS. Levene's Test produced an  $F$ -value of 2.868, which implies equal variances can be assumed [ $F = 2.868, p = 0.096$ ].

The results of the ANCOVA showed that there was a statistically significant difference on the depressive symptoms between the intervention and control groups, [ $F(1,55) = 6.051, MSE = 96.888, p = .017$ ]. The partial Eta Squared value,  $\eta^2 = 0.099$ , indicated a large effect size of nearly 10%. The strength of the relationship between the expressive group counseling and the change in depressive symptoms was large. At the same time, the mean scores of the Center for Epidemiological Studies Depression (CES-D) for participants in the intervention group on the post-test had decreased, while the mean scores of the CES-D for participants in the control group on the post-test had increased. The Korean immigrant women in the intervention group showed decreased depressive symptoms after participating in the expressive group counseling interventions, whereas the Korean immigrant women in the control group experienced more depressive symptoms at the post-test of CES-D compared to the pre-test of CES-D. See Tables 6 to 8 for result of ANCOVAs.

**Table 6**

*Descriptive Statistics on Depressive Symptoms Pre-Test*

Group	$M$	$SD$	$N$
Intervention group	16.966	10.878	29
Control group	18.241	11.792	29
Total	17.603	11.262	58

**Table 7***Descriptive Statistics on Depressive Symptoms Post-Test*

Group	<i>M</i>	<i>SD</i>	<i>N</i>
Intervention group	14.207	9.443	29
Control group	21.552	15.863	29
Total	17.879	13.460	58

**Table 8***ANCOVA Test of Depressive Symptoms*

Source	Sum of squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
Pres-Test	4215.065	1	4215.065	43.504	.000
Groups	586.269	1	586.269	6.051	.017
Error	5328.866	55	96.888		

**Data Analysis for Participants' Post-Session Self-Reports Survey in the Intervention Group**

A post-session survey was given to participants in the intervention group one week after the conclusion of the treatment. In the post-session survey, first, a Likert-type scale was used (0= not at all to 3=most useful) to examine participants' summative evaluation in the impact of the particular expressive interventions and group counseling among Korean immigrant women in the United States. Secondly, an open-ended question was used to provide detailed information or additional comments about the participants' experiences of using expressive interventions in the group counseling setting.

Means ranged from 1.80 to 2.48 across all interventions. Responses with a mean of 0.01 to 1.0 were considered as an activity that was somewhat useful. Those activities with a mean of

1.01 to 2.0 were considered as moderately useful, and greater than 2.00 were considered as the most useful. The respondents rated *Drumming* ( $M = 1.79$ ) and *Dance* ( $M = 1.79$ ) as moderately useful activities. The activities such as *decorating or painting* ( $M = 2.48$ ), *Sandtray* ( $M = 2.48$ ), *writing* ( $M = 2.24$ ), *mandals* ( $M = 2.24$ ), and *meditation* ( $M = 2.03$ ) rated as most useful activities. In overall ratings in group counseling with other Korean women, the majority of participants (75.9%) rated *most useful* (see Table 8). A greater percentage of participants reported as *most useful* (86.2%) having the group facilitated by a Korean woman. See Tables 9 and 10 more detailed information about all participants' preference of using expressive interventions in group counseling.

**Table 9**

*Mean Score and Percentage of Participants Rating for Usefulness of Activity*

Activity	$M (SD)$	0	1	2	3
		Not at all (%)	Some useful (%)	Moderately useful (%)	Most useful (%)
Decorating or painting	2.48 (0.738)	0	13.8	24.1	62.1
Sandtray	2.48 (0.688)	0	10.3	31.0	58.6
Writing	2.24 (0.912)	6.9	10.3	34.5	48.3
Meditation	2.04 (0.865)	0	34.5	27.6	37.9
Mandalas	2.48 (0.785)	3.4	6.9	27.6	62.1
Drumming	1.79 (1.048)	10.3	34.5	20.7	34.5
Dance	1.79 (1.048)	10.3	34.5	20.7	34.5

**Table 10***Mean Score and Percentage of Participants Rating for Group Counseling*

Group Counseling	<i>M (SD)</i>	0 Not at all (%)	1 Some useful (%)	2 Moderately useful (%)	3 Most useful (%)
Meeting as a group with other Korean women	2.690 (0.604)	0	6.9	17.2	75.9
Having the group facilitated by a Korean woman	2.828 (0.468)	0	3.4	10.3	86.2

Responses to the open-ended question were coded by two researchers using content analysis to generate themes (Brantlinger, Jimenez, Klingner, Pugach, & Richardson, 2005). Conventional content analysis helped researchers to organize qualitative responses into explicit categories determining common themes (Hsieh & Shannon, 2005) and gathering meaning from the responses (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2009). The researchers read through all open-ended responses regarding participants' experiences with expressive group counseling interventions from the post-session survey. Using a constant comparative analysis (Creswell, 2014), responses were categorized into a new code. The researchers only categorized the most frequently mentioned responses. Researchers found that most responses fit into seven themes. See Table 11 for these themes and sample open-ended responses regarding participants' experience with expressive intervention and group counseling.

**Table 11***Themes from Open-Ended Questionnaire*

Themes	N (%)	Sample Quotation
Needs more expressive group counseling sessions	21 (72.41)	“Just opened my mind and felt exciting to know myself and feel sad that it is over. Hope we have more sessions
Having empathetic and a supportive relationship	18 (62.07)	“Supporting each group members helped to encourage me to heal myself”
Increasing self-awareness and self-actualization	16 (55.17)	“This group gave me a chance to be aware of who I am and how to take care of myself”
Understanding others	13 (44.83)	“It helped me to understand others’ feelings and thoughts through expressive group counseling”
Expressing feeling and thoughts	13 (44.83)	“Each activity assisted me to explore my feeling in front other group members and learned it is good to express my feelings”
Recognizing strengths and weaknesses	10 (34.48)	“I found out that I have many strengths and I am proud of myself. I also learned how to change my weaknesses to strengths”
Learning effective coping strategies	7 (24.14)	“I learned many coping skills that I can use to control my negative feelings”

## **CHAPTER V:**

### **DISCUSSION**

This chapter discusses the findings of the present study of the relationship between acculturative stress and depressive symptoms in the Korean immigrant women in order to evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. Limitations of research are addressed, as well as implications for counseling and recommendations for future research.

#### **Discussion of the Findings**

The purpose of this study was to evaluate the relationship between acculturative stress and depressive symptoms in Korean immigrant women and to evaluate the use of expressive group counseling interventions for these women's acculturative stress and depressive symptoms. Fifty-eight participants were randomly assigned either to the intervention group (n = 29) or the control group (n = 29). Participants in this study were between the ages of 27 and 74 years, and did not receive any additional mental health treatment in the period of conducting the study. Twenty-nine participants in the intervention group met twice weekly for two weeks for a total of four sessions of expressive interventions, whereas twenty-nine participants in the control group received a coloring activity as a placebo that included four pages of printed pictures, some coloring pencils, and instructions to color each of the pictures on specific days during the two-week period. Post-test data was collected one week after the end of the interventions.

#### **Relationship Between Acculturative Stress and Depressive Symptoms**

Prior researchers have indicated that acculturative stress is associated with depression (Rhee, 2009; Tummala-Narra et al., 2012) or depressive symptoms (Oh et al., 2002; Rhee, 2016) among various groups of immigrants in the U.S. The researcher hypothesized that acculturative stress in Korean women who have immigrated to the United States and live in the southern and

central regions of Texas would be related to depressive symptoms positively. The researcher found that there was a positive association between acculturative stress and depressive symptoms in the Korean immigrant women who participated in this study. This finding suggests that acculturative stress scores may be used to predict depressive symptoms in Korean immigrant women in the United States. These women, while adjusting to the new culture, may experience psychological distress in the form of depressive symptoms.

### **Effect of the Expressive Group Counseling Interventions for Acculturative Stress**

Acculturative stress is what immigrants may experience during the process of acculturation while they attempt to solve their problems with conflicts of adjustment and integration into a new culture (Berry & Kim, 1988). The researcher hypothesized that there would be a significant difference in changes in acculturative stress between the women who participated in expressive group counseling interventions and the women who did not participate in the interventions. The results of the ANCOVA indicated no statistically significant difference in the post-test scores of the Acculturative Stress Index (ASI) between the intervention and control groups.

The researcher found that the mean scores of acculturative stress for both the intervention and control groups had increased from pre-test ( $M = 54.28$  in the intervention group,  $M = 56.58$  in the control group) to the post-test ( $M = 55.1$  in the intervention group,  $M = 57.72$  in the control group). The levels of acculturative stress in both the intervention and control groups' participants of this study (the mean ASI scores = 55.1 in intervention group and the mean ASI scores = 57.7 in control group) were higher than the levels of acculturative stress (the mean ASI score = 34-40) found in the Korean immigrants who lived in the cities of southwestern Ohio, the north central region of Kentucky, and southern Indiana (Rhee, 2016). However, the levels of acculturative stress in both the intervention and control groups' participants in this study (the

mean ASI scores = 55.1 in intervention group and the mean ASI scores = 57.7 in control group) were lower than the levels of acculturative stress (the mean ASI score = 66) found in Korean immigrants residing in Canada (Noh & Avison, 1996). This finding suggests that acculturative stress might be associated with various personal factors, including the environments of the participants in the studies. This finding also suggests that the Korean immigrant women in this study are having difficulty adjusting to the U.S. and are experiencing distress, even though the participants in both the intervention and control groups have lived in the U.S. for more than 18 years on average. Because ASI scores vary by location and increased (but not significantly) following the intervention, it is possible that Korean immigrant women's acculturation anxiety may be more responsive to environmental factors, such as the political, social, and media climate than to counseling. During the study, there was a strong anti-immigrant political climate in which it is possible that the participants heard about immigrants losing their green cards and being deported. Actions such as deportations of immigrants might raise or solidify acculturation anxiety. However, this factor could not be accounted for in this study.

### **Effect of the Expressive Group Counseling Interventions for Depressive Symptoms**

According to previous studies, Korean immigrants reported higher levels of depressive symptoms than other Asian and non-Asian immigrant subgroups (Ayers et al., 2009; Bernstein et al., 2011; Gavrilovic, 2012; Hurh & Kim, 1990; Kim et al., 2015; Jang et al., 2011; Kuo, 1984; Min et al., 2005; Shin, 1993). It was hypothesized that there would be a significant difference in changes in depressive symptoms for Korean women who immigrated to the United States and participated in expressive group counseling interventions than for Korean women who immigrated to the United States and did not participate in expressive group counseling interventions. The results of ANCOVA showed that the mean score of post-tests on the depressive symptoms was a significant decrease for the intervention group ( $M = 14.21$ )



compared to the control group ( $M=21.55$ ). Expressive group counseling interventions appear to have resulted in the reduction of the level of depressive symptoms among Korean immigrant women in the United States. This finding suggests that the culturally focused expressive group counseling interventions can be used to help Korean immigrant women develop successful coping strategies to reduce depressive symptoms.

### **Impact of Particular Intervention and Group Counseling Setting**

Participants in the intervention group reported that Mandalas was the most useful expressive intervention while drumming and dance were somewhat useful for the Korean immigrant women in this study. The majority of participants (75.9%) in the intervention group rated that working with other Korean immigrant women in the group counseling was most useful. Additionally, more than 86% of participants in the intervention group reported that having a Korean woman as a group facilitator was mostly beneficial for them. Which of these factors actually contributed most to the lowering of depressive symptoms is not known, but the women in this study seemed to value interacting with other Korean immigrant women, participating in traditional Korean modes of expression, and having the group led by a Korean immigrant woman who could serve as a model for how Koreans can develop effective coping mechanisms.

### **Limitations of Research**

This study examined acculturative stress and depressive symptoms among Korean immigrant women in the United States. The findings provide understanding into Korean immigrant women's mental health needs that can inform prevention and intervention programs. However, the present study had several limitations. First, participants were recruited based on their accessibility and willingness to participate in the research. This convenience sampling method means that the participants may not provide an accurate representation of the population of all Korean immigrant women in the United States. Therefore, counselors should use caution in

generalizing from the results in this study. Second, the participants size was small ( $N = 58$ ) and the participants were from south and central Texas. The participants in the current study cannot be considered to be representative of all other Korean immigrant women residing in different regions of the U.S. where Korean communities vary in size. In the small Korean communities, the researcher expects that Korean immigrant women would have more difficulty adjusting to new culture with limited social support, while Korean immigrant women who live in larger Korean communities might have less difficulty adjusting to the new culture because they may have more social resources and support.

Self-report measurements were used to obtain the data for this study. The participants in this study may have responded in a socially desirable way. It is possible that the participants did not want to appear negative or problematic related to the mental health issues and cultural norm. Socially desirable or acceptable responding would modify the statistical results of the study. Additionally, the participants' biases could have influenced the results of the study. Because the Korean community is fairly small in this part of the country, it is possible that some of the control group members may have communicated with some of the intervention group members and recognized that the coloring activity was not a mental health intervention. Thus, some control group members may have answered post-test surveys knowing that their mental health was not expected to improve.

Also because of the small Korean communities in the region, participants in the intervention group may have had established close relationships with some other participants in the intervention group. This may have limited their comfort of self-expression and caused them to share their feeling and experiences less during the group counseling sessions. This also, however, may have opened them up to expressing their feelings more openly with other members outside of the counseling sessions.

Previous studies (Curry & Kasser, 2005; Vennet & Serice, 2012) have indicated that coloring is related to reduced anxiety. Thus, the control group may have received a treatment, even though the coloring activity was not processed with a counselor.

The study was limited to a three-week period. Post-test data was collected one week following the conclusion of the treatment. It is not clear how long lasting any effects of the expressive intervention counseling experience will be on the depressive symptoms in the Korean immigrant participants. It is possible that the decrease in depressive symptoms will be short term, though the decrease also could be long term.

A final limitation of this study is that the dual roles of the researcher could have affected the results of the study. Because of the challenge of finding qualified Korean counselors who are fluent in the Korean language, the researcher also served as the facilitator (counselor) for the expressive group counseling interventions in the study. Even though the participants in the intervention group were blind to the fact that they were in the intervention group for this study, the participants in the intervention group might have provided desirable responses on the post-test to please the group facilitator (the researcher) or as an expression of their appreciation for having the expressive group counseling experience.

### **Implications**

Even though the findings in the present study may not be generalizable to the larger population of Korean immigrant women in the United States, it is important for service providers, including mental health professionals, in the Korean community to be informed of the findings.

As the results of this study suggest, acculturative stress needs to be managed to prevent or reduce depressive symptoms in Korean immigrant women in the U.S. The mental health professionals should understand the relationship between acculturative stress and depressive symptoms for this population. Although the findings of this study did not support one of the

proposed hypotheses, the findings of this study provide researchers and mental health professionals with greater insight related to acculturative stress in Korean immigrant women in the south and central Texas. Due to limited and short expressive group counseling sessions, participants had only identified their psychological distress, but did not have time to work on the acculturative stress.

The findings of this study contribute to the field of the expressive and group counseling by deepening the understanding of the expressive group counseling intervention for Korean immigrant women's depressive symptoms, a form of psychological distress, in the U.S. In addition, the findings of this study can help to develop effective and culturally adapted approaches for counseling Korean immigrant women in the U.S.

Furthermore, the study shows that depressive symptoms can decrease independently of acculturative stress, even though there is a clear relationship between acculturative stress and depressive symptoms for Korean immigrant women. According to the participants, the expressive group counseling interventions helped the participants to better understand themselves and others and to obtain emotional support from the group members in this population. The results of this study suggest that counselors need to introduce adequate treatments and resources into the Korean community to help Korean immigrant women who experience depressive symptoms. Recognizing that 86.2% of the intervention group participants identify that having a Korean woman facilitate the counseling group indicates that the counseling profession needs to train more Koreans who speak the Korean language to provide counseling services to Korean immigrants.

### **Recommendations for Future Research**

This study's results indicate important information with the quantitative findings that appear to validate the relationship between acculturative stress and depressive symptoms in

Korean immigrant women and the effect of expressive group counseling intervention for these women's acculturative stress and depressive symptoms. The current research supports culturally appropriate interventions for Korean immigrant women to suggest successful coping strategies to prevent or reduce depressive symptoms among Korean immigrant women. The current research study suggests there are couple of recommendation for future research to explore.

First, the participants in the study was small, with a total of 58 Korean immigrant women, and the participants included Korean immigrant women only from a limited region in Texas. Future research should include larger, more diverse samples to increase generalizability to Korean immigrant women throughout the United States. This research should use varied Korean counselors as facilitators instead of just the primary researcher. Furthermore, with a larger sample size, future research could investigate the effectiveness of the interventions with Korean immigrant women of different ages and lengths of time living in the U.S. Research also could be expanded to include Korean immigrant men.

Second, this research was brief. It included only four sessions over a two-week period. Although the results of the present study showed that there was no statistically significant effects of the expressive group counseling interventions in the acculturative stress, it is possible that acculturative stress is more resistant to change than depressive symptoms, and longer treatment may be more effective in reducing both acculturative stress and depressive symptoms. Future studies might examine how expanding treatment to 8 or 10 weekly expressive intervention group counseling sessions might affect acculturative stress and depressive symptoms. Researchers also could evaluate the long-term effects of treatment by testing acculturative stress and depressive symptoms six months and one year after treatment instead of just one week following treatment.

Lastly, although the quantitative results of the current study indicate the effectiveness of expressive group counseling intervention in reducing the depressive symptoms of Korean

immigrant women in the U.S., research is lacking on culturally sensitive and language appropriate mental health treatments for Koreans. Future research should employ both qualitative and quantitative methods to expand the general knowledge about counseling interventions for Koreans. Is group counseling with other Koreans, led by Korean counselors more effective? Are expressive interventions more effective than other talk therapy interventions? Do the most effective interventions involve art, movement, meditation, or other elements of the interventions chosen for this study? Through further examination of counseling interventions with Korean immigrants, counselors can learn how to more effectively serve the Korean immigrant community in the U.S.

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**APPENDIX A:**  
**INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL LETTER**

ST. MARY'S UNIVERSITY



May 23, 2018

Sunkyung Chung  
Dept. of Counseling  
St. Mary's University

DELIVERED BY EMAIL TRANSMISSION

Dear Ms. Chung:

The IRB has approved the study, Sunkyung Chung (M. Harper, faculty Sponsor), The Effects of Using Expressive Interventions Among Korean Immigrant Women In South And Central Texas: A Pilot Experimental Study.

If research participants have any questions about their rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Dan Ratliff, Ph.D.  
IRB Chair  
St. Mary's University

The proposal is determined to meet criteria for exemption under 45 CFR 46.101(b)(2), the use of survey procedures with de-identified, minimal risk data. Exempt research does not require IRB review or renewal for five years (2023). However, IRB requests a closure report when the data collection is completed, or, if active data collection continues, a summary report of the sample size at the May IRB meeting of each academic year.

Exempt research can proceed with an abbreviated consent process in which the subjects are informed of the purpose and duration of the survey, and with no signature necessary for informed consent. The approval stamp must be visible in the information about the study provided to potential subjects. I abbreviated the title so that the control group would not be clued to their status.

You may collect data from human subjects according to the approved research protocol. The approval stamp must appear on any Information Form or Informed Consent Form approved by the IRB (jpeg file attached).

**APPENDIX B:**  
**RECRUITMENT FLYER-ENGLISH VERSION**



**Are you a Korean woman who immigrated to the United States after your 16<sup>th</sup> birthday  
and has been living in the United States for at least six months?**

**Are you experiencing any difficulties in adjusting to living in the United States?**

**Do you sometimes feel unhappy, sad, or hopeless?**

**If you answered YES to these questions,  
or If you know someone who may answer Yes to these questions  
then you may be able to participate in this research study.**

The purpose of this study is to test expressive counseling activities with Korean immigrant women to see if these activities help reduce stress and emotional discomfort related to living in the United States.

To learn more about this research or to participate in this study,  
please contact Sunkyung Chung at 972-904-1777 or [schung@mail.stmarytx.edu](mailto:schung@mail.stmarytx.edu)

This is a research study conducted by a doctoral student at St Mary's University under the supervision of Dr. Melanie C. Harper, [mharper@stmarytx.edu](mailto:mharper@stmarytx.edu). This research has been approved by the Institutional Review Board at St Mary's University.



## What is Expressive Therapy Intervention?

The use of the creative arts (e.g. arts, crafts, writing, music) as a form of therapy intervention to assist to have quality of life through expressive self and to understand emotions .



- Are you a Korean woman who immigrated to the United States after your 16<sup>th</sup> birthday and has been living in the United States for at least six months?
- Are you experiencing any difficulties in adjusting to living in the United States?
- Do you sometimes feel unhappy, sad, or hopeless?

**If you answered YES or you know someone who may answer YES to these questions, then you may be able to participant in this research study.**

- The purpose of this study is to test expressive counseling activities with Korean immigrant women to see if these activities help reduce stress and emotional discomfort related to living in the United States.
- To learn more about this research or to participant in this study, please contact Sunkyung Chung at 972-904-1777 or [schung@mail.stmarytx.edu](mailto:schung@mail.stmarytx.edu)
- This is a research study conducted by a doctoral student at St Mary’s University under the supervision of Dr. Melanie C. Harper, [mharper@stmarytx.edu](mailto:mharper@stmarytx.edu). This research has been approved by the Institutional Review Board at St Mary’s University.

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**APPENDIX C:**  
**RECRUITMENT FLYER-KOREAN VERSION**



귀하께서는 한국나이 만 16 세 생일 이후에 미국으로 이주하였으며  
최소 6 개월이상 거주하신 한국 여성이신가요?  
미국에 이주하신 후 적응하시기에 어떤 겪고 계신가요?  
불행하다, 슬프다 혹은 희망적이지 않다라고 느끼신적이 있으신가요?

만약 귀하께서 위의 질문에 "예"라고 답하신다면,  
혹은 아는 한국인 여성분 중에 위와 같은 질문에 "예"라고 답 하실 분을 아신다면  
귀하 또는 그 여성분은 이 연구에 아마도 참가 하 실 수 있으실 것입니다.

이 연구의 목적은 표현방법을 이용한 상담 기법이 한국이민여성분들이 미국에 살면서  
받았던 스트레스와 불편한 감정들을 줄일 수 있는지 알아보기 위한 연구 입니다.

보다 많은 정보 혹은 참여를 원하신다면  
정선경 (972-904-1777 or chung@mail.stmarytx.edu)에게 연락주시면 감사하겠습니다.  
이 연구는 St Mary's University 박사과정의 학생에 의해 이루어 지며 Dr. Melanie C.  
Harper (mharper@stmarytx.edu)의 관리 감독 아래 행해집니다. 이연구는 St Mary's  
University 의 임상시험위원회 (IRB)의 동의를 받은 연구임을 알려 드립니다.



**APPENDIX D:****THE REQUEST LETTER FOR PERMISSION TO USE FACILITIES**

March 10, 2018

Dear Sunkyung Chung,

As the priest of St. Andrew Kim Korean Catholic Church in Austin, Texas, I am authorized to grant you permission to use our church facilities for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. You will be able to recruit research participants from our church, and conduct counseling groups at our church with members of the community who volunteer to participate in this study, and gather pre- and post-study data from participants at our church. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

Gunsuck Chung  
Priest Ft. Francesco



March 10, 2018

Dear Sunkyung Chung,

As the president of San Antonio Korean American Association in San Antonio, Texas, I am authorized to grant you permission to use our association facilities for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. You will be able to recruit research participants from our association, and conduct counseling groups at our association office with members of the community who volunteer to participate in this study, and gather pre- and post-study data from participants at our church. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

Myung Ho Lee  
President of San Antonio Korean American Association

March 10, 2018

Dear Sunkyung Chung,

As the director of San Antonio Korean language school in San Antonio, Texas, I am authorized to grant you permission to use our school facilities for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. You will be able to recruit research participants from our school, and conduct counseling groups at our school with members of the community who volunteer to participate in this study, and gather pre- and post-study data from participants at our church. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

Jaehyun Yang  
Director of San Antonio Korean Language School

March 10, 2018

Dear Sunkyung Chung,

As interim Executive Director of the Rape Crisis Center in San Antonio, Texas, I am authorized to grant you permission to use our center facilities for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. You will be able to conduct counseling groups at our center with members of the community who volunteer to participate in this study, and gather pre- and post-study data from participants at our church. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

Deana Franks  
Interim Executive Director at The Rape Crisis Center at San Antonio, Texas

**APPENDIX E:**

**THE REQUEST LETTER FOR PERMISSION TO DISPLAY RECRUITMENT FLYER**

March 10, 2018

Dear Sunkyung Chung,

As owner of the Seoul Asian Market and Café in San Antonio, Texas, I am authorized to grant you permission to post flyers at our business. These flyers will be for the purpose of recruiting participants for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

March 10, 2018

Dear Sunkyung Chung,

As owner of the Korean Market in San Antonio, Texas, I am authorized to grant you permission to post flyers at our business. These flyers will be for the purpose of recruiting participants for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

March 10, 2018

Dear Sunkyung Chung,

As owner of the Seoul garden restaurant in San Antonio, Texas, I am authorized to grant you permission to post flyers at our business. These flyers will be for the purpose of recruiting participants for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

March 10, 2018

Dear Sunkyung Chung,

As owner of the Kim's Galbi restaurant in San Antonio, Texas, I am authorized to grant you permission to post flyers at our business. These flyers will be for the purpose of recruiting participants for your research study regarding the use of expressive interventions group counseling on acculturative stress and depressive symptoms among Korean immigrant women. I realize that you are a doctoral student at St. Mary's University, San Antonio, Texas, and are conducting this research under the supervision of Dr. Melanie C. Harper and with the permission of the St. Mary's University Institutional Review Board (prior to beginning the research).

If you have any questions, please contact me at \_\_\_\_\_

Sincerely,

**APPENDIX F:**  
**DEMOGRAPHIC QUESTIONNAIRE**

**일반적 신상정보**

The following questions ask about your general background information.

다음 질문들은 귀하의 일반적인 정보에 대한 질문들입니다.

1. What is your age: 당신의 나이는? \_\_\_\_\_ (years old, 세)
  
2. How long have you lived in the United States? \_\_\_\_\_ (year, 년)  
미국에서 얼마나 오래 사셨나요?
  
3. What is your marital status?  
현재 귀하의 혼인상태는?
 

<input type="checkbox"/> Single, never married	싱글, 결혼한 적이 없다.
<input type="checkbox"/> Married or domestic partnership	기혼 혹은 동거 중
<input type="checkbox"/> Widowed	사별
<input type="checkbox"/> Divorced or separated	이혼 혹은 별거
<input type="checkbox"/> Other (Please specify): 기타 (구체적으로 적어주세요)	
  
4. Are there children in the household for whom you feel you have responsibility?  Yes 네  No 아니오  
책임을 느끼는 아이들과 함께 살고 계신가요?  
  
If yes, how old are the children?  
만약 있으시다면, 아이들은 몇 살인가요?
  
5. Since you moved to the United States, have you lived with a U.S. citizen as a partner at any time?  
미국으로 이주한 후에 미국 시민권자의 배우자 혹은 파트너와 사신 적이 있으신가요?  
  
 Yes, 네  No 아니오



6. What is your religious preference?  
귀하는 종교를 가지고 있습니까?

- |  |            |
|--|------------|
| <input type="checkbox"/> Protestant                                  | 기독교        |
| <input type="checkbox"/> Catholic                                    | 카톨릭        |
| <input type="checkbox"/> Buddhist                                    | 불교         |
| <input type="checkbox"/> Confucian                                   | 유교         |
| <input type="checkbox"/> No religion                                 | 무교/ 종교가 없음 |
| <input type="checkbox"/> Other (Please specify):<br>기타 (구체적으로 적어주세요) |            |

7. What is the highest degree or level of school you have completed? If currently enrolled, highest degree received (either in Korea or the United States).

당신이 마친 학교 중 가장 높은 학위 또는 레벨은 무엇입니까? 현재 등록중이라면, 받은 학위 중에 가장 높은 학위를 적어주세요 ( 한국과 미국 모두 포함)

- |  |            |
|--|------------|
| <input type="checkbox"/> No Schooling completed                                  | 학교를 다니지 않음 |
| <input type="checkbox"/> Elementary school                                       | 국민학교/초등학교  |
| <input type="checkbox"/> Middle school   | 중학교        |
| <input type="checkbox"/> High school   | 고등학교       |
| <input type="checkbox"/> Some college credit, no degree                          | 2년제 대학교    |
| <input type="checkbox"/> Bachelor's degree                                       | 대학교/학사     |
| <input type="checkbox"/> Master's degree   | 석사         |
| <input type="checkbox"/> Doctorate or professional degree                        | 박사         |
| <input type="checkbox"/> GED or other (Please specify):<br>기타/검정고시 (구체적으로 적어주세요) |            |

## 8. Employment Status:

귀하는 현재 직업이 있습니까?

- |   |                |
|---|----------------|
| <input type="checkbox"/> Employed for wages                             | 파트타임/아르바이트     |
| <input type="checkbox"/> Self-employed                                  | 자영업            |
| <input type="checkbox"/> Out of work and looking for work               | 무직이나 취업 준비중    |
| <input type="checkbox"/> Out of work but not currently looking for work | 무직이고 준비하지 않음.  |
| <input type="checkbox"/> A housewife not looking for work               | 가정주부, 일을 찾지 않음 |
| <input type="checkbox"/> A student                                      | 학생             |
| <input type="checkbox"/> Retired  | 퇴직             |
| <input type="checkbox"/> Unable to work                                 | 일을 할 수 없음      |
| <input type="checkbox"/> Other (please specify)                         |                |
- 기타 (구체적으로 적어주세요)

## 9. Rate your proficiency at the following skills in English skills:

당신의 영어 능력을 평가해주세요.

	<b>Not at all</b> 전혀 못함	<b>Not well</b> 잘 못함	<b>Well</b> 보통	<b>Very Well</b> 매우 잘함
<b>Speaking</b> 말하기				
<b>Writing</b> 쓰기				
<b>Reading</b> 읽기				
<b>Listening</b> 듣기				

10. Which of the following best represents how you view your ethnic identity?

귀하는 자신을 어떻게 평가하십니까?

- |  |                   |
|--|-------------------|
| <input type="checkbox"/> I'm Korean.                     | 나는 한국인이다..        |
| <input type="checkbox"/> I'm mostly Korean.              | 나는 거의 한국인이다.      |
| <input type="checkbox"/> I'm half Korean, half American. | 나는 한국인과 미국인 반반이다. |
| <input type="checkbox"/> I'm mostly American.            | 나는 거의 미국인이다.      |
| <input type="checkbox"/> I'm American.                   | 나는 미국인이다.         |

11. Which of the following best represents your friends' ethnic identities?

귀하와 친한 친구들은 어느 나라 사람입니까?

- |   |                    |
|---|--------------------|
| <input type="checkbox"/> Only Korean                                  | 한국 사람만             |
| <input type="checkbox"/> Mostly Korean and a few American<br>or other | 대부분 한국 사람, 몇명의 미국인 |
| <input type="checkbox"/> Half Korean and half American or other       | 한국인과 미국인 비슷하게      |
| <input type="checkbox"/> Mostly American or other and<br>a few Korean | 대부분 미국 사람, 몇명의 한국인 |
| <input type="checkbox"/> Only American or other non-Korean            | 미국 사람만 혹은 한국인이 아닌  |

**APPENDIX G:**  
**ACCULTURATIVE STRESS INDEX (ASI)**

미국 생활 중 겪는 어려움

Instructions: Items below ask you the degree to which you are undergoing difficulties while adjusting to living in America. **Please circle the appropriate number for each statement.**

다음은 귀하께서 미국생활 중에 경험 할 수 있는 어려움에 관한 질문들입니다. 귀하의 경험을 가장 잘 나타내는 번호 한 개를 골라 O 표를 해주십시오.

- |                |                |
|----------------|----------------|
| 1 = Never      | 1 = 전혀 겪지 않는다. |
| 2 = Sometimes  | 2 = 가끔 겪는다.    |
| 3 = Often      | 3 = 자주 겪는다.    |
| 4 = Very often | 4 = 매우 자주 겪는다. |

**How often do you experience difficulties in the following areas because of your ability to speak and understand English?**

당신은 아래와 같은 상황에서 영어로 인한 어려움을 얼마나 자주 경험하십니까?

**I experience difficulties when:**

	<i>Never</i> 전혀 겪지 않는다	<i>Sometimes</i> 간혹 겪는다	<i>Often</i> 자주 겪는다	<i>Very often</i> 매우 자주 겪는다
1. I talk to children. 아이들과 대화할 때.	1	2	3	4
2. I am at work. 일을 할 때 (직장, 학교, 기타 등등에서).	1	2	3	4
3. I read a newspaper/magazine. 신문이나 잡지, 책을 읽을 때.	1	2	3	4
4. I try to understand official documents (i.e., tax forms). 공문서를 읽을 때 (예, 세금 보고서).	1	2	3	4
5. I go shopping. 쇼핑 할 때.	1	2	3	4
6. I try to understand the TV/radio. TV를 보거나 라디오를 들을 때.	1	2	3	4

**Please tell me how often you experience stress because of the following circumstances.**

당신은 얼마나 자주 다음과 같은 이유 때문에 미국에 사는 것이 어렵다고 느끼십니까?

**I feel that living in America is stressful because:**

	<i>Never</i> 전혀 격지 않는다	<i>Sometimes</i> 간혹 격는다	<i>Often</i> 자주 격는다	<i>Very often</i> 매우 자주 격는다
7. I lack the opportunity to visit Korea. 한국을 방문할 기회가 부족하기 때문에.	1	2	3	4
8. I am living away from my family, relatives and friends. 가족, 친척, 친구들과 떨어져 살기 때문에.	1	2	3	4
9. I am unable to do the things I used to enjoy when I was in Korea. 한국에서 즐기던 일들을 더 이상 하지 못하기 때문에.	1	2	3	4
10. I am not able to find someone I can confide in. 신뢰할 수 있는 사람을 찾지 못해서.	1	2	3	4
11. I do not have good and/or close friends. 진정한 친구가 없기 때문에.	1	2	3	4
12. I am mistreated by other Koreans. 다른 한국인들로부터 부당한 취급을 받아서.	1	2	3	4
13. I have a job that is below my experience and qualifications. 나의 자격이나 경력에 미치지 못하는 직업 때문에.	1	2	3	4
14. The job experience I had in Korea is not recognized in the U.S. 한국에서의 경력을 인정받지 못하기 때문에.	1	2	3	4
15. My education in Korea is not recognized at work. 한국에서의 학력을 인정받지 못하기 때문에.	1	2	3	4
16. I am unable to find adequate social support or a social group in the U.S. 사회적인 지지나 기반의 부족 때문에.	1	2	3	4
17. Others discriminate against me. 차별을 받아서.	1	2	3	4
18. I am treated as an alien by others. 이방인 취급을 당해서.	1	2	3	4

	<i>Never</i> 전혀 격지 않는다	<i>Sometimes</i> 간혹 격는다	<i>Often</i> 자주 격는다	<i>Very often</i> 매우 자주 격는다
19. I do not understand the school or educational system in the U.S. 미국의 학교나 교육제도를 이해하지 못해서.	1	2	3	4
20. I have few, if any, opportunities to participate in American politics. 미국의 정치에 참여할 기회의 부족때문에.	1	2	3	4
21. I am constantly reminded by others of my minority status. 남들로부터 나의 소수민족 됨을 계속 상기 받기때문에	1	2	3	4
22. I feel helpless to make political decisions. 정치적 결정에 아무 영향력을 행사할 수 없으므로.	1	2	3	4
23. I have few, if any, opportunities to earn more income. 돈을 더 많이 벌 수 있는 기회가 부족하다.	1	2	3	4
24. I am disappointed that my standard of living is not what I had for when I first came to the U.S. 지금 생활 수준이 미국에 처음 왔을 때보다 못하기 때문에.	1	2	3	4
25. I am not able to have time for, or have money for, a vacation. 휴가를 즐길 시간과 돈의 여유가 없기 때문에.	1	2	3	4
26. I feel that my relationship with my spouse would be better if I was living in Korea. 한국이었다면 배우자와의 관계가 더 좋았을 것이기 때문에.	1	2	3	4
27. I worry about the future of my children. 자녀들의 장래가 걱정되기 때문에.	1	2	3	4
28. I feel anxious that my children will grow up and not respect my spouse and I as parents. 자녀들이 자라서 나를 부모로서 공경하지 않을 까봐.	1	2	3	4
29. I worry about my family members losing cohesion with each other and I would not have to worry about this family problem if I lived in Korea. 한국이었다면 걱정하지 않았을 가족간의 소원함 때문에.	1	2	3	4
30. I frequently argue with my spouse. 배우자와 잦은 말다툼 때문에.	1	2	3	4

	<i>Never</i> 전혀 격지 않는다	<i>Sometimes</i> 간혹 격는다	<i>Often</i> 자주 격는다	<i>Very often</i> 매우 자주 격는다
31. I feel that the relationship between my spouse and my parents has gotten worse since I have come to the U.S. 남편과 친정 부모 혹은 아내와 시부모 관계가 미국에 온 후 나빠졌기 때문에.	1	2	3	4

**APPENDIX H:**  
**CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE (CES-D)**  
**우울증 검사지**

Instructions: Below is a list of the ways that you might have felt or behaved. **Please tell me how often you have felt this way during the past week by circling the appropriate number.** For each statement choose from the following alternatives:

다음은 당신이 겪을 수 있는 감정이나 느낌에 관한 질문입니다. 지난 일주일 동안 당신이 얼마나 자주 다음과 같은 느낌이나 감정을 경험하였는지 가장 잘 나타내주는 번호 한 개에 O 표를 해주십시오.

- |   |                                     |
|---|-------------------------------------|
| <b>0 = Rarely or none of the time (less than 1 day)</b>         | <b>0 = 전혀/거의 없었다 (일주일에 1 일 미만)</b>  |
| <b>1 = Some or a little of the time (1-2 days)</b>              | <b>1 = 간혹 있었다 (일주일에 1-2 일)</b>      |
| <b>2 = Occasionally or a moderate amount of time (3-4 days)</b> | <b>2 = 자주 있었다 (일주일에 3-4 일)</b>      |
| <b>3 = Most or all of the time (5-7 days)</b>                   | <b>3 = 대부분/ 항상 있었다 (일주일에 5-7 일)</b> |

**How often have you felt this way during the past week?**

지난 일주일 동안 일상 생활 중에 당신은 얼마나 자주 다음과 같이 느끼셨습니까?

	Rarely or none of the time (less than 1 day) (전혀/거의)	Some or a little of the time (1-2 days) (간혹)	Occasionally or a moderate amount of time (3-4 days) (자주)	Most or all of the time (5-7 days) (대부분/항상)
1. I was bothered by things that usually don't bother me. 평소에는 대수롭지 않던 일로 심란해졌다.	0	1	2	3
2. I did not feel like eating; my appetite was poor. 입맛이 없고 식욕이 떨어졌다.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends. 가족이나 주위 사람들의 도움에도 우울한 기분을 떨쳐 버릴 수가 없었다.	0	1	2	3
4. I felt I was just as good as other people. 나도 남들만큼 괜찮은 사람이라고 느꼈다.	0	1	2	3
5. I had trouble keeping my mind on what I was doing. 일에 집중할 수가 없었다.	0	1	2	3
6. I felt depressed. 우울하게 느껴졌다.	0	1	2	3
7. I felt that everything I did was an effort. 모든 일들이 힘겹게 느껴졌다.	0	1	2	3
8. I felt hopeful about the future. 미래가 희망적이라고 느껴졌다.	0	1	2	3
9. I thought my life had been a failure. 실패한 인생을 살았다고 여겨졌다.	0	1	2	3



	Rarely or none of the time (less than 1 day) (전혀/거의)	Some or a little of the time (1-2 days) (간혹)	Occasionally or a moderate amount of time (3-4 days) (자주)	Most or all of the time (5-7 days) (대부분/항상)
10. I felt fearful. 두려운 마음이 들었다.	0	1	2	3
11. My sleep was restless. 잠을 설쳤다.	0	1	2	3
12. I was happy. 행복했다.	0	1	2	3
13. I talked less than usual. 평소보다 말수가 줄었다.	0	1	2	3
14. I felt lonely. 외롭게 느껴졌다.	0	1	2	3
15. People were unfriendly. 주위 사람들이 불친절했다.	0	1	2	3
16. I enjoyed life. 삶이 즐겁다고 느꼈다.	0	1	2	3
17. I had crying spells. 이유없이 자꾸 눈물이 나왔다.	0	1	2	3
18. I felt sad. 슬프게 느껴졌다.	0	1	2	3
19. I felt that people dislike me. 사람들이 나를 싫어한다고 느꼈다.	0	1	2	3
20. I could not get "going". 매사에 의욕이 없었다.	0	1	2	3

**APPENDIX I:**  
**POST-SESSION SURVEY**

**상담 후 평가 설문지**

Please circle the answer that best describes your experience of the usefulness of each activity you experienced in this counseling group.

당신의 경험을 토대로 각각의 활동에 대해 도움이 된 정도에 따라 0 표 해주십시오.

	Not at all useful 전혀 도움이 안됨	Some useful 약간 도움이 됨	Moderately useful 적당히 도움이 됨	Most Useful 매우 도움이 됨
1. Decorating or painting 꾸미기 혹은 색칠하기	0	1	2	3
2. Sandtray 모래치료	0	1	2	3
3. Writing 글쓰기	0	1	2	3
4. Meditation 명상	0	1	2	3
5. Mandalas 만달라 그리기	0	1	2	3
6. Drumming 드러밍	0	1	2	3
7. Dance 춤	0	1	2	3
8. Meeting as a group with other Korean women 다른 한국 여성들과의 집단상담	0	1	2	3
9. Having the group facilitated by a Korean woman 한국 여성이 진행하는 집단 상담	0	1	2	3

**Please feel free to provide any additional comments regarding your experience with this counseling group?**

당신께서 이 집단상담 안에서 경험한 것에 대해 추가적인 의견이 있으시면 적어주세요

**APPENDIX J:**  
**INFORMED CONSENT FORM FOR PARTICIPANT IN RESEARCH STUDY-**  
**ENGLISH VERSION**

**Information About Participation in Research Study:  
Expressive Activities with Korean Immigrant Women**

**Principal Investigator**

Sunkyung Chung, M.A., RPT, LPC  
 Doctoral Student in the Counselor Education and Supervision Program  
 St Mary's University, San Antonio, TX  
 Contact Information: chung@mail.stmarytx.edu or 972-904-1777

You are being asked to participate in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. This information form provides information to you about the research, which helps you to make an informed decision. Please read the following information carefully. You should feel free to ask the researcher any questions if there is anything that is not clear or if you need more information.

**Why am I being asked?**

You have been asked to participate in the research because you are a Korean immigrant woman who: 1) was born in Korea; 2) lives in the southern or central region of Texas; 3) is at least 18 years old; 4) immigrated to the U.S. from Korea on or after your 16th birthday; 5) has lived in the United States more than six months; 6) are able to speak, read, and write Korean; 7) currently does not receive any mental health treatment, and 8) believes that you experience some difficulties, stress, loneliness, sadness, or unhappiness related to your relocation to the United States.

**What is the purpose of this research?**

The purpose of this study is to evaluate the relationship between acculturative stress and depressive symptoms in Korean immigrant women and to evaluate the use of expressive activities for helping Korean immigrant women deal with stress and unwanted feelings.

**What procedures are involved?**

This research will be performed at a location in the community and will be conducted over a three-week period. You will be asked to complete three surveys during the first meeting (approximately 30 minutes), and you will be asked to participate in activities either alone or in a group during the following two weeks.

If you are asked to perform activities in a group, the group will meet at the same community location five times, twice during the first week and twice during the second week for approximately 90 minutes at each meeting. During the third week, you will be asked to return to the community location to complete three surveys. This should take you approximately 20 minutes.

If you are asked to perform activities alone, you will be given the activities and instructions at the first meeting when you complete the three surveys (approximately 30 minutes), and you will return during the third week to complete two surveys. This second meeting will take approximately 30 minutes. The activities that you will perform alone during the first and second week will take no more than 30 minutes each on two days during the first week and two days during the second week. All materials that you will need to complete these activities will be provided at the first meeting.

### **What are the potential risks and discomforts?**

The possible risks of participating in this study are minimal. Although the activities are designed to promote wellbeing, it is possible that you may experience some uncomfortable thoughts or feelings as you complete the surveys and participate in the activities. If you experience uncomfortable thoughts or feelings as a result of the activities, the researcher will be available to discuss these thoughts or feelings with you. There are no anticipated physical risks associated with participating in this study.

### **What are the primary benefits to taking part in the research?**

You may benefit from this research by gaining new coping strategies and increasing your understand of your emotions and thoughts. The findings of this research study will increase our understanding about Korean immigrant women and strategies that may help mental health workers assist them. As compensation for your time and participation in this study, you will receive a \$10 gift card to HEB Grocery Store at the completion of the study (HEB has contributed the gift cards to support this study).

### **What are the costs for participating in this research?**

There is no cost, other than your time, for participating in this research study.

### **How will my privacy and confidentiality be protected?**

The only place where your name will appear in this research study will be on a list of participants and codes that the researcher will keep during the study so that she can match each participant's data from the first meeting's surveys with data from the last meeting's surveys. Only an identifying code will be placed on the actual surveys, so please do not write any identifying information on your surveys. The researcher will protect your name and code by storing it in a locked cabinet in a locked room until the final surveys have been coded and given to the appropriate participants. After the coding has been completed, the researcher will shred and dispose of the document that contained the participant's names and codes.

The coded surveys (with no identifying information) will be stored in a locked cabinet at the researcher's home. According to university policy, the coded surveys will be kept for five years after the completion of the research study, and then they will be shredded. The only people who will have access to the research data and consent forms are the researcher and her faculty supervisor.

### **Can I withdraw or be removed from the study?**

Your participation in this study is voluntary. You can choose not to participate or to leave the study at any time. Your decision to participate or not to participate will not affect your current or future opportunities. The researcher also has the right to withdraw you from participation in this study if she believes that you could be harmed by the study or you are unable to complete the requirements of the study.

### **Who should I contact if I have questions?**

You can contact the researcher, Sunkyung Chung, 972-904-1777 or chung@mail.stmarytx.edu. You also can contact the researcher's faculty advisor, Dr. Melanie C. Harper, 210-438-6400 or mharper@stmarytx.edu.

### **What are my right as a research participant?**

*If you have any questions about your rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.*

**How will the results be used?**

The results of this research study is to be submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counselor Education and Supervision at St Mary's University in San Antonio, Texas. The results will be published in a dissertation, and the researcher plans to present the results at conferences and in professional journals. The results will be used for educational purposes. No identities of participants will be disclosed in any presentation or publication.

**Agreement of Participant**

I have read or someone has read to me the above information. I understand the information, I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

**APPENDIX K:**  
**INFORMED CONSENT FORM FOR PARTICIPANT IN RESEARCH STUDY-**  
**KOREAN VERSION**

**연구 참여 동의서:**  
**한국 이민 여성의 표현 활동**

**연구 책임자**

정선경(Sunkyung Chung), M.A., NCC, RPT, LPC  
 카운셀러 교육 및 감독 프로그램의 박사과정 학생  
 세인트 메리 대학교, 샌안토니오, 텍사스  
 연락처: chung@mail.stmarytx.edu 혹은 972-904-1777

귀하는 이 연구에 참여해 달라는 요청을 받으셨습니다. 귀하가 참여 여부를 결정하시기 전에, 본 연구가 진행되는 이유와 연구의 필요성을 이해하시는 것이 중요합니다. 이 동의서는 해당 연구에 대한 정보를 제공하여 귀하께서 정보에 근거한 결정을 내리시는 데 도움이 될 것입니다. 다음 내용들을 주의 깊게 읽어주세요. 만약 명확하지 않은 점이 있거나 더 많은 정보가 필요한 경우 연구원에게 언제든지 질문하시면 됩니다.

**연구 참여자로 선정된 이유는 무엇인가요?**

귀하가 이 연구의 참여 대상으로 선정되신 이유는 귀하가 한국 이민 여성으로, 1) 한국에서 태어났고; 2) 텍사스의 중심부, 또는 남부에서 살고 있으며; 3) 최소 18세 이상이고; 4) 16살 생일 이후에 한국에서 미국으로 이민을 왔으며; 5) 미국에서 6개월 이상 거주하였고; 6) 한국어를 말하고, 읽고, 쓸 수 있으며; 7) 현재 정신과 치료를 받지 않는 상태이고; 8) 미국에서 생활함에 있어 어려움, 스트레스, 외로움, 슬픔, 또는 행복하지 않은 감정들을 경험했을 것으로 예상되기 때문입니다.

**이 연구의 목적은?**

이 연구의 목적은 한국 이민 여성들의 미국 사회 적응에 따른 스트레스와 우울증 증상의 연관 관계를 알아보기 위함입니다. 또한 이러한 스트레스와 원치 않는 감정들을 해소하는 데 있어 '표현 활동'들이 어떤 역할을 하는 지 평가하고자 합니다.

**이 연구의 진행 과정은?**

본 연구는 지역 사회에 위치하고 있는 장소에서 3주에 걸쳐 진행될 예정입니다. 귀하는 첫 번째 미팅에서 (30분 정도 소요 예정) 세 개의 설문지에 답변하게 될 것입니다. 이후 2주 간은 혼자, 또는 그룹으로 모여 연구에 참여하시게 됩니다.

만일 귀하가 그룹으로 이 연구에 참여하시게 되면, 해당 그룹은 같은 장소에서 다섯 차례 만나게 됩니다. 첫 주에 2회, 두 번째 주에 2회씩 미팅을 갖게 되는데 각각 90분씩 소요될 예정입니다. 마지막 주에는 같은 장소로 오셔서 세 개의 설문지 작성을 완료하시면 됩니다. 이 마지막 미팅은 약 20분 정도 소요될 것으로 예상됩니다.

만일 귀하가 혼자 연구에 참여하시게 되면, 첫 번째 미팅에서 활동과 지시 사항을 듣고

세 개의 설문지에 답변하시게 됩니다. 그리고 3주 후 같은 장소에서 두 개의 설문지를 작성하시면 됩니다. 미팅 시간은 각 30분 정도씩 소요될 예정입니다. 귀하는 2주 동안 한 주에 2일, 총 4회에 걸쳐 혼자 표현 활동을 하시게 됩니다(각 활동은 30분 미만 소요). 위 활동을 하기 위해 필요한 모든 자료는 첫번째 미팅에서 모두 제공됩니다.

### 가능한 문제점이나 어려움이 있나요?

이 연구 참여를 통해 겪을 수 있는 문제점은 거의 없습니다. 이 연구에서 진행될 표현 활동은 귀하의 행복을 증대시키기 위해 설계됐지만, 혹 설문지를 작성하시거나 표현 활동을 하면서 불편한 감정을 느끼실 수 있습니다. 만일 귀하가 본 연구 활동으로 인해 불편한 감정이나 느낌을 경험하시면, 연구자와 이러한 감정들에 대해 의논할 수 있습니다. 본 연구 참여로 인해 예상되는 신체적인 위험은 없습니다.

### 본 연구에 참여해서 얻을 수 있는 보상은?

귀하가 이 연구에 참여하시게 되면 새로운 스트레스 대처 전략에 대해 알 수 있고, 귀하의 감정과 생각을 더 잘 이해 할 수 있게 될 것으로 생각됩니다. 또한 이 연구는 한국인 이민 여성들에 대한 이해를 보다 높일 수 있고, 정신 보건 복지사들이 이들을 도울 수 있는 전략을 짜는 데 큰 도움을 줄 것입니다. 귀하가 이 연구를 위해 도움을 주시는 데 대해 HEB Grocery Store 10 달러 기프트 카드를 증정해 드릴 예정입니다. (HEB는 본 연구를 지원하기 위해 기프트 카드를 협찬하였습니다)

### 연구 참가를 위해 필요한 경비가 있나요?

이 행사 참가에 필요한 경비는 귀하가 할애해 주시는 시간 외에는 전혀 없습니다.

### 나의 사생활과 비밀은 어떻게 보안이 되나요?

연구가 진행되는 동안 귀하의 이름이 표시되는 유일한 곳은 연구 참가자 명단이며 이 서약서이며, 첫번째 미팅과 마지막 미팅에서 작성하실 설문지에는 코드가 발급돼 해당 신원을 확인하게 됩니다. 식별코드는 실제로 사용 될 설문지에만 표시되므로 설문지에 개인의 신상 정보는 쓰지마십시오. 연구자는 귀하의 이름과 사용된 식별코드를 보호하기 위해 잠겨 있는 방안에 잠긴장치가 장착되어 있는 캐비닛안에 마지막 설문지가 작성되어 암호화 될때까지 보관 될 것입니다.

암호화 된 설문지는 (개인신상정보가 포함 되지 않음) 연구자의 집, 잠긴장치가 장착되어 있는 캐비닛안에 보관 되어 질 것입니다. 대학 규정에 따라, 암호화 된 설문지들은 연구 종료 이후 5년 동안 보관되며 그 이후에는 폐기 됩니다. 연구 자료와 서약서에 접근할 수 있는 유일한 사람은 연구원 본인과 연구원의 지도 교수입니다.

### 연구 참여를 중단할 수 있나요?

귀하는 연구 활동 참가와 중단을 언제든 선택하실 수 있습니다. 이 선택은 현재, 혹은 미래의 활동 기회에 전혀 영향을 주지 않을 것입니다. 또한 연구 도중 귀하에게 무리가 된다고 생각되는 상황이 생기거나, 연구 활동을 끝까지 할 자격이 없다고 판단될 시, 연구원 역시 귀하에게 활동을 중단시킬 권리가 있습니다.

### 질문 사항이 있으면 어디로 연락하면 되나요?



궁금한 내용이 있으면 정선경 연구원에게 972-904-1777 전화 주시거나 또는 schung@mail.stmarytx.edu로 연락주시면 됩니다. 또한 연구원의 지도 교수인 Dr. Melanie C. Harper, 멜라니 씨. 하퍼 박사님께, 210-438-6400 혹은 mharper@stmarytx.edu, 질문하실 수 있습니다.

### 연구 참여자로서의 권리에 어떤 것들이 있나요?

*만약 귀하께서 참여자로서의 권리에 대해 궁금하시거나, 이 연구와 관련해 걱정되는 것이 있다면 아래로 연락 주시면 됩니다. 세인트 메리즈 대학의 임상연구심의위원회 의장 전화 210-436-3736 혹은 이메일 IRBCommitteeChair@stmarytx.edu.*

### 연구 결과는 어떻게 사용되나요?

본 연구 결과는 St Mary's University in San Antonio, Texas의 상담자 교육 및 감독 철학에 대한 박사 학위를 위한 자료로 활용됩니다. 연구 결과는 논문으로 발표되며, 본 연구원은 전문 잡지와 학회에도 위 내용을 소개할 예정입니다. 연구 결과는 교육적 목적으로 사용됩니다. 프레젠테이션이나 출판물에는 연구 참여자의 개인 신원은 전혀 노출되지 않습니다. 참가자의 동의

본인은 위 정보를 직접, 또는 제 3자를 통해 읽었음을 확인합니다. 본인은 해당 내용을 이해하였고, 질문을 할 수 있는 기회를 가졌으며, 만족스러운 답변을 들었습니다. 또한 본인이 이 연구에 자발적으로 참여하며, 이유 없이 참여를 언제든지 중단할 수 있다는 사실도 이해하고 있습니다. 위 서약서의 복사본을 소유할 수 있다는 사실도 확인하였습니다. 본인은 본 연구에 자발적으로 참여하는 데 동의합니다.

**APPENDIX L:**

**INFORMED CONSENT FORM FOR PARTICIPANT IN RESEARCH STUDY-**

**BACK TRANSLATION KOREAN TO ENGLISH VERSION**

**Consent Form for Participation in Research Study:  
Expressive Activities with Korean Immigrant Women**

**Principal Investigator**

Sunkyung Chung, M.A., RPT, LPC

Doctoral Student in the Counselor Education and Supervision Program

St Mary's University, San Antonio, TX

Contact Information: chung@mail.stmarytx.edu or 972-904-1777

You are invited to participate in this research study. Before you decide to participate in this research, it is important for you to understand the reason and procedure of the research. This consent form will give you the information regarding the study, and help you to make decision. Please read this form carefully. If you are concerned or need more information, ask the researcher anytime.

**Why am I asked to participate in this study?**

You are being invited for this research, because you are a Korean immigrant woman who: 1) was born in Korea; 2) lives in central or south Texas; 3) is at least 18 years old; 4) immigrated to the U.S from Korea after your 16th birthday; 5) has lived in the U.S for more than 6 months; 6) can speak, read, write Korean; 7) has not currently received any kind of mental health treatment; 8) has difficulties, stress, loneliness, sadness, and unhappy feelings while living and adapting in the U.S.

**What is the purpose of this research?**

The purpose of this research is to examine the relationships between acculturative stress and the symptoms of depression among Korean immigrant women in the U.S. Additionally, this study will evaluate how 'expressive actions' can help release these stress and unwanted emotions among Korean immigrant women.

**What is the procedure of this study?**

This research will be held at a place in the community for 3 weeks. You will be answering three surveys in your first meeting (it will take about 30 min). And for the rest of the two weeks, you will participate in this research alone or with a group.

If you are asked to work as a group, your group will meet at the same place for 5 times. You will meet twice a week for two weeks and it will take about 1.5 hours each meeting. You will be asked to complete three surveys and return the surveys to the same place in the community during the third week. This will take about 20 minutes.

If you are asked to participate in this study alone, you will be asked to answer three surveys after you receive the activity and the directions at the first meeting. Three weeks later, you will be asked to answer two surveys and return the surveys to the same place in the community. Each meeting will take 30 minutes. Additionally, you will be performing an 'expressive activity' for two weeks, 2 days per one week

(each activity will take less than 30 min). Researcher at the first meeting will give all the materials needed for this activity.

**Is there any possible problem or risk?**

A small number of possible risks can exist while participating in this research. Even though the expressive activities in this study are designed to increase your wellbeing, you may experience uncomfortable thoughts or feelings while answering surveys or doing expressive activities. If you have these uncomfortable experiences, you may discuss your uncomfortable thoughts or feelings with the researcher. No physical risk or problem is expected while participating in the study.

**What are the benefits?**

You may learn about new stress coping strategies and understand more about your emotions and feelings from this study. The result of this study will help mental health providers to better understand of Korean immigrant women and to provide better solutions for helping the Korean immigrant women. You will also get \$10 gift card from HEB Grocery Store. (HEB has contributed this gift card to help the study.)

**Is there any cost for participating in this study?**

There is no cost needed except your time contributed for the study.

**How will my privacy be protected?**

Your name will be only shown on a list of participants and the researcher will give codes during the study. The codes will be used to collect the participant's data from surveys at the first and last meetings. The identifying code will be only appeared on the actual surveys, please do not write any of your personal information on your surveys while answering survey questions. The researcher will protect your name and identifying code in a locked cabinet, which is located in a locked room until the last surveys will be transferred into the codes, and distributed to the matched participants. After finalizing the coding of the data, the researcher will share the surveys and other documents that included the participants' names and identifying codes.

According to the university policy, the coded surveys (without personal identifying information) will be stored safely in the locked cabinet at the researcher's home. These coded surveys will be retained for five years after the completion of the research and will be shredded.

**Can I withdraw or stop participating from the research?**

Your participation in this study is voluntary. You can withdraw or stop to participation in this research anytime you want to. Your withdrawing or stopping will not affect your present and future opportunities. The researcher also has the right to drop you from this research study, when she believe that you may be harmed by this study or you are not able to finish the requirements of this study.

**Who should I contact if I have questions?**

If you have any questions, please contact the researcher, Sunkyung Chung, 972-904-1777 or chung@mail.stmarytx.edu. You can also contact to her supervisor, Dr. Melanie C. Harper (210-438-6400 or mharper@stmarytx.edu).

**What are the rights of the participants?**

*If you are curious about the rights of the participants or have concerns regarding this research study, please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.*

**How will the research data be used?**

This research data will be used for the requirements for the degree of Doctor of Philosophy in Counselor Education and Supervision at St Mary's University in San Antonio, Texas. The results will be published in a dissertation and expected to be presented in professional journals and at conferences. The results will be used ~~in~~ for educational purposes only. No personal information of participants will be shown in any presentation or publication.

**Agreement of Participant**

I have read all the above information directly or through another person. I understand all the above contents and information, and I had opportunities to ask questions and get satisfactory answers. I am aware that I'm participating in this research study voluntarily and I can voluntarily withdraw from this research study without notification for any reason. I understand that I can have a copy of this consent form. I voluntarily agree to participate in this study.

**APPENDIX M:**  
**INFORMED CONSENT FORM FOR PARTICIPANT IN INTERVENTION GROUP-**  
**ENGLISH VERSION**

**EXPRESSIVE GROUP COUNSELING CONSENT**

**Sunkyung Chung, MA, NCC, RPT, LPC (TX 68870)**

**schung@mail.stmarytx.edu or 972-904-1777**

**Welcome to Your Group Experience!**

The success of group counseling depends upon a high degree of trust among you, your group facilitator, and fellow group members. This document has been prepared to inform you about what to expect from group counseling and from your group facilitator.

**Qualifications**

I have a Master of Arts degree in Marriage and Family Therapy from the St Mary's University at San Antonio, Texas and am currently working on a doctoral degree in Counselor Education and Supervision at the same university. I have a license as a professional counselor (LPC) from the states of Texas, and I am a Registered Play Therapist (RPT). I have counseled individuals in a variety of settings and with varied age groups, including children, adolescents, young adults, and adults. I have focused my work in depression, anxiety, sexual trauma, immigration, and women's issues.

**Understanding Group Counseling**

Group counseling is a process of understanding more about yourself and others in a safe environment. In group, you will have the opportunity to explore patterns of thinking and behaving that are similar to how you relate to others in your life.

Objectives of group counseling include, but are not limited to:

- Develop coping skills to assist you in dealing with stress, difficulties, and unwanted thoughts and feelings
- Feel a sense of support from other group members
- Understand more about yourself
- Identify and explore thoughts, feelings, and behaviors

You are welcome to share as much or as little about yourself while in the group, however, the more open you are, the better experience you may have. You are welcome to ask questions at any time.

**A Safe Environment**

A safe environment is created and maintained by both the facilitator of a group and its members. Primary ingredients are mutual respect and a chance to create trust. Another primary ingredient for a safe environment has to do with confidentiality. Your group facilitator is bound by law to maintain confidentiality. As a group member, you are bound by honor to keep within the group whatever is said in the group by other group members. We realize that you may want to share what you are learning about yourself in group with a significant other. This is fine as long as you remember not to talk about others in the group or how events unfold in group or in any other way compromise the confidentiality of other group members.

## Confidentiality

It is important that you feel comfortable in group to talk freely. Sometimes you might want to discuss things that you do not want those outside of the group to know. You have the expectation of privacy in group sessions. All members of the group will be asked to agree to a high level of confidentiality in the group sessions. This means that each participant agrees not to share any other group member's identifying and personal information with others. It is appropriate to share your personal reactions and feelings about group with others, but **please do not share other people's stories with anyone outside of the group.**

Your confidentiality is protected by state regulations. I will keep your communication and records confidential and securely stored. In general, I will not discuss what you say with others. However, in some situations state regulations and professional ethics may require me to release limited information to others without your permission. These situations are as follows:

- If you are a threat to yourself or others (showing suicidal or homicidal intent), I may contact medical or law enforcement professionals in order to keep you and others safe. <sup>[1]</sup><sub>SEP</sub>
- If you say something that makes me suspect that physical, emotional, or sexual abuse or neglect is occurring to a minor, ad disabled person, or an elderly person; I am required to report this to the Texas Department of Family and Protective Services (DFPS) in order to protect that individual. <sup>[1]</sup><sub>SEP</sub>
- Although I do not anticipate to hear from a court of law, if a court of law orders a subpoena of case records or orders me to testify about you, I will first check with you to determine if you want your records released. (Any records are created at the individual level and do not mention other group members.) If you do not want your records released, then I will fight the subpoena. If the judge determines that the records must be released, I will release only the information required by the judge
- Records may also be released if you request their release in writing. Records will include only your personal progress in group—not information about other group members. Counseling notes will not include research data. <sup>[1]</sup><sub>SEP</sub>
- I may consult with my faculty advisor or a member of my dissertation committee regarding group interactions. This allows me to gain other perspectives and ideas concerning how best to help you. No identifying information will be shared if I choose to consult with others.
- E-mail interactions and mobile phone conversations may not be secure. Although my e-mail account is a secure account, your e-mail provider may store your e-mail interactions, and mobile phone conversations can be intercepted. Therefore, by signing this document, you understand that if you decide to correspondence with me by e-mail or mobile phone, there is a potential for confidentiality to be compromised.

All records are kept for a period of 5 years past the last counseling session, at which time they are disposed of in a legal and confidential manner. In the event that I become incapacitated or unable to practice, the dissolution of my counseling practice and keeper of records is assigned to Dr. Melanie C. Harper, LPC-S. As a keeper of records, she will act in my stead for contact regarding your records. She may be contacted by phone (210-438-6400) or e-mail (mharper@stmarytx.edu).

## Client Rights and Responsibilities

As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

You agree to come to counseling free from the influences of drugs and alcohol. I also have the right to terminate our counseling relationship if I believe it is in your best interest. I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards.

## **Complaints**

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns or if you need further assistance, please contact my faculty advisor, Dr. Melanie C. Harper, LPC-S (210-438-6400 or mharper@stmarytx.edu). You may also submit a complaint to the Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only. If you choose to file a complaint, I will not retaliate in any way.

## **Fee**

This is free counseling. There is no fee.

## **Consistent Attendance**

Your presence in group is highly important. A group dynamic is formed that helps create an environment for growth and change. If you are absent from the group, this dynamic suffers and affects your experience and the experiences of other group members. Therefore, I ask that you make this commitment a top priority for the duration of the group. It is understood that occasionally an emergency may occur that will prevent you from attending group. If you are faced with an emergency or sudden illness, please contact me before group begins to let me know that you will not be present.

## **Potential Benefits of Group Counseling**

Participating in expressive group counseling can result in a number of benefits to you, including a better understanding of your personal goals and values, improving personal relationships, and resolution of specific problems you are facing in your life. It is important to recognize that counseling is not magic, and change does not occur overnight. Your willingness to participate fully in group and your openness to take feedback will play a role in how much you gain in counseling.

## **Potential Risks of Group Counseling**

There can be discomfort involved in participating in expressive group counseling. You may remember unpleasant events or experience feelings of anger, fear, anxiety, sadness, frustration, loneliness, helplessness, or other unwanted feelings. If these distressful emotions arise during counseling, please talk with your group and with me. During the process of expressive group counseling, it is normal to have intense feelings and reactions to other group members or even towards me. Again, these are understandable emotions that should be discussed and processed in the group setting.

## **Emergencies**

I can be reached during normal business hours Monday through Friday by calling at 972-904-1777 or e-mailing schung@mail.stmarytx.edu. I may not be immediately available to handle emergency situations. **If you are in need of emergency assistance, call '911'** or the crisis response team for your county of residency. Unless otherwise specified, I will return phone messages within 24 hours.

## **Referrals**

If it becomes clear that you are not benefiting from group counseling or you need more care than can be given in this counseling format, I will terminate our counseling relationship and provide you with referrals. You may obtain a second opinion from another mental health professional, you may choose to follow up with those referral sources or other mental health professionals, or you may discontinue counseling. If at any time you would like referrals, please let me know.

**Signature of Group Participant**

Thank you for the time and attention that you took to read this document. I have read the above information, have asked questions as needed, and understand the issues related to risks and benefits of counseling, confidentiality, professional records, and alternative treatments.

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Print Group Participant's Name

Date

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Group Participant's Signature

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Print Group Facilitator's Name

Date

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Facilitator's Signature



**APPENDIX N:**  
**INFORMED CONSENT FORM FOR PARTICIPANT IN INTERVENTION GROUP-**  
**KOREAN VERSION**

집단 표현 상담 서약서

Sunkyung Chung, MA, RPT, LPC (TX 68870)  
 chung@mail.stmarytx.edu or 972-904-1777

**집단상담에 참여하신 것을 환영합니다!**

집단상담의 성공 여부는 이 집단 상담에 참여하는 귀하, 귀하와 함께 하는 집단 구성원들, 그리고 이 집단상담을 이끄러가는 집단상담사와의 상호간의 믿음에 따라 좌우됩니다. 위 서류는 귀하께서 해당한 집단상담과 집단상담 저(집단상담사)는 에 대한 정보를 알려드리기 위해 작성했습니다.

**집단상담사의 자격 요건**

저(본 집단상담을 진행 할 상담사)는 텍사스 주의 쉐안토니오에 위치하고 있는 세인트 메리즈 대학교에서 “결혼과 가족상담학” 석사학위를 공부하였으며, 현재 같은 대학의 대학원에서 “상담 교육과 감독” 박사 과정을 밟고 있습니다. 저는 텍사스 주에서 발급한 전문 상담 자격증(LPC)을 소지하고 있으며, 정식 놀이 치료사(RPT)로도 등록돼 있습니다. 저는 어린이, 노인, 청년층, 그리고 중년층을 포함한 다양한 연령대와 다양한 환경에서 상담을 진행한 이력이 있습니다. 저는 현재 우울, 분노, 성적 학대에서 발생하는 트라우마, 이민, 그리고 여성 관련 분야에 관심을 갖고 있습니다.

**집단상담에 대한 이해**

집단상담은 안전한 환경에서 자신과 타인에 대해 더 많이 이해하는 과정입니다. 귀하는 집단상담을 통해 삶 속에서 자신이 다른 사람들과 어떠한 방식으로 관계하고, 행동하고, 사고 하는 지등을 알아볼 수 있는 기회가 될 것입니다.

집단 상담의 목표는 아래와 같습니다:

- 스트레스, 어려움, 또는 원치 않는 생각 및 감정을 다루는데 도움이 되는 대처방안 혹은 대처 기술 발달
- 다른 구성원들로부터 지지를 얻고 더욱 공감할 수 있게 됨
- 자신에 대해 더 많이 이해하게 됨
- 생각, 감정, 그리고 행동들을 인식하고 이해하게 됨

집단상담 중에 본인에 관하여 많이 혹은 적게 공개하고 공유 하실 지 여부는 귀하께서 결정할 수 있습니다. 다만, 자신에 대해 더 많이 공개하고 공유하신다면, 보다 많은 풍부한 경험들을 하실 수 있을 것입니다. 관련된 궁금한 사항이 있으시면 언제든지 질문해주세요.

**안전한 환경**

집단상담사와 집단 구성원들은 안정적인 환경을 만들고 이를 유지 할 것입니다. 이를 위해 필요한 요소는 상호간의 존경과 믿음을 형성할 수 있는 기회입니다. 또 다른 주요 요소는 비밀 보장입니다. 집단상담사는 상담 내용을 비밀 유지해야 할 법적 의무가 있습니다. 집단 구성원로서, 귀하 역시 다른 구성원들이 집단상담에서 언급한 내용을 철저히 비밀로 유지해 주셔야 합니다. 상담 중에

본인 스스로에 대해 알게 된 내용을 외부로 공개하는 것은 자유입니다. 그러나 본인 외의 다른 구성원에 대한 내용이나 집단 내에서 일어난 일들은 어떠한 경우에도 철저히 비밀을 유지하여야 합니다.

### 비밀 보장

귀하가 상담 중에 편안한 마음으로 자유롭게 이야기할 수 있는 것은 매우 중요합니다. 때로는 집단상담 외부의 사람들이 알기를 원치 않는 것에 대해 토론하고 싶을 수도 있습니다. 왜냐하면 귀하는 집단상담 안에서 개인 정보 보호와 비밀 보장을 기대하기 때문입니다. 따라서 모든 집단 구성원들은 상담을 진행하는 동안 높은 수준의 비밀 보장에 대한 서약을 하게 됩니다. 즉, 각 참가자들은 다른 구성원들의 신원정보 및 개인 정보를 다른 사람과 공유하지 않고 구성원들의 개인 정보가 공개될 수 있는 내용을 절대 외부에 공개하지 않는다는 것에 동의합니다. 본인이 상담을 통해 얻은 개인적인 반응이나 감정들을 외부로 공개하는 것은 상관없습니다. 그러나 **집단 구성원들의 이야기를 외부에서 언급 혹은 공유하는 것은 금기시 됩니다.**

귀하의 개인 정보는 텍사스 주 규제에 의해 보호됩니다. 저(집단상담사)는 귀하의 의사와 기록들을 철저히 비밀리에 보관하고 관리할 것입니다. 저(집단상담사)는 귀하와 나눈 대화에 대해 절대 다른 누구와도 언급하지 않을 것입니다. 그러나 텍사스 주 규제와 직업상의 윤리 문제로 귀하의 동의 없이 외부에 제한된 정보를 알릴 상황이 생길 수 있습니다. 그 상황들은 아래와 같습니다:

- 만약 귀하가 자신이나 타인에게 위협이 되는 경우 (자살 또는 살인 의도 표시), 저(집단상담사)는 귀하와 다른 사람들을 안전하게 지키기 위해 의료 또는 법 집행 기관에 연락 할 수 있습니다.
- 만약 귀하가 언급한 내용이 장애인, 또는 노약자에게 신체적, 감정적, 혹은 성적인 학대나 방치를 의심하게 하는 경우, 저(집단상담사)는 해당 대상자를 보호하기 위해 이 내용을 텍사스 가정 보호 서비스 (DFPS)에 보고할 수 있습니다.
- 법원으로 부터 연락을 기대 하지는 않지만, 만약 법원이 소송 기록 소환을 명령하거나 귀하에 대한 증언을 명령하는 경우, 저(집단상담사)는 귀하에게 먼저 해당 내용의 공개 여부를 확인 할 것입니다. (모든 기록은 개인 레벨에서 작성되며 다른 구성원은 언급하지 않습니다). 만약 귀하가 본인의 기록을 노출하는 것을 원하지 않는다면, 저(집단상담사)는 법원과 다툴 의지가 있습니다. 만약 추후에, 판사가 기록을 반드시 공개해야 한다고 판단하거나 결정을 내린다면, 귀하의 관련 사항을 판사에게 요구한 필요한 정보만 공개 할 것입니다.
- 만약 귀하가 서면으로 기록 공개 요청을 하신다면, 귀하의 기록은 공개 될 수 있습니다. 이 기록에는 집단상담 동안 귀하의 개인적인 진행 과정에 대한 정보만을 포함할 것이며 다른 구성원의 정보는 공개되지 않습니다. 상담 진행에 관한 기록은 연구 데이터를 포함하지 않습니다.
- 저(집단상담사)는 집단 내의 상호 작용에 관하여 저의 감독 교수, 또는 논문 위원회와 상의 할 수 있습니다. 이 과정은 저(집단상담사)가 상담 구성원들을 도울 수 있는 또 다른 관점이나 아이디어 제공할 수 있기 때문입니다. 이러한 내용을 상의하더라도, 상담자들의 개인 정보가 노출되는 일은 일어나지 않을 것입니다.
- 이메일 통한 정보 공유나 휴대폰 대화 내용 등은 보안되지 않을 수 있습니다. 저(집단상담사)의 개인 이메일 계정은 보안된 상태이나, 혹 귀하의 이메일 계정에서 정보를 저장하거나, 휴대폰의 대화 내용이 노출될 수 있습니다. 따라서 이 서약서에 서명을 할 시, 귀하는 이메일이나 휴대전화로 나눈 저(집단상담사)와의 대화가 보안되지 않을 수 있다는 것에 유의하셔야 합니다.

모든 정보는 마지막 상담 이후 5년 동안 보관됩니다. 그 이후에는 법적 절차를 거쳐 비밀리에 폐기됩니다. 만약 저(집단상담사)가 스스로 위 내용을 처리할 수 없게 된다면, 상담 기록은 모두 멜라니 씨. 하퍼 박사님(Dr. Melanie C. Harper, LPC-S)에게 이관됩니다. 기록의 보유자로서 하퍼 박사님(Dr. Melanie)께서 모든 의무를 이행하게 됩니다. 궁금한 사항이 있다면 21-438-6400 으로 전화주시거나, mharper@stmarytx.edu 로 이메일을 보내주세요.

### 의뢰인의 권리 및 책임

의뢰인으로서, 귀하는 저(집단상담사)와의 상담 관계를 언제든 종료할 수 있는 권리가 있습니다. 저(집단상담사)의 상담 기술이나 조언이 본인에게 해가 된다고 생각되면 언제든 이를 거절하거나 상의할 권리도 있습니다. 또한 귀하는 상담 참여시 중독성이 강한 약물을 복용하거나 혹은 음주 상태로 참여하지 않을 것을 동의합니다. 저(집단상담사)도 이와 동일하게 귀하의 상담 여부에 따라 상담 관계를 종료할 수 있는 권한이 있습니다. 저(집단상담사)는 귀하에게 제공 될 상담이 법적규율과 윤리적인 기준 아래 전문적으로 이루어지고 있음을 알려드립니다.

## 불만 사항

만약 상담에 관해 불편함이 있으시다면, 언제든지 저(집단상담사)에게 알려주십시오. 만약 제(집단상담사)가 귀하의 걱정을 해소할 수 없거나, 별도의 도움이 필요하다고 생각되면 감독관인 멜라니 씨. 하퍼 박사(Dr. Melanie C. Harper, LPC-S, 210-438-6400 or mharper@stmarytx.edu)께 연락하시면 됩니다. 또한 아래 주소로(Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 ) 항의서를 보내거나 1-800-942-5540 로 전화하셔서 항의서에 관련된 양식이나 해당 정보를 더 얻을 수 있습니다. 위 연락처는 불만 사항만을 접수하기 위한 곳입니다. 만약 쉬하께서 불만을 제기하기로 선택하신 경우, 저(집단상담사)는 어떠한 방식으로든 보복 혹은 앙갚음을 하지 않을 것을 알려 드립니다.

## 발생 비용

상담은 무료로 진행됩니다.

## 정기적인 참석

귀하의 정기적인 상담 참여는 굉장히 중요합니다. 집단 내에서의 이러한 활동은 성장하고 변화할 수 있는 환경을 만들어 줍니다. 상담에 결석하면, 다른 구성원들과 귀하의 경험에 큰 영향을 미칠 수 있습니다. 따라서 저(집단상담사)는 귀하에게 정기적이고 규칙적인 집단 상담의 참석을 가장 우선시해주시길 부탁드립니다. 그러나 응급 상황이 생겨 집단 상담에 불참하실 수 있습니다. 만약 이러한 응급 상황이나 급작스런 병으로 인해 결석을 하게 될 시, 저(집단상담사)에게 먼저 귀하의 참석 여부를 먼저 알려주시길 부탁드립니다.

## 집단 상담의 가능한 보상들

집단 표현 상담에 참여하면 귀하에게 몇 가지의 보상이 주어질 것입니다. 본인의 목표나 가치에 대해 더 큰 이해를 할 수 있고, 본인의 개인적인 관계를 개선할 수 있으며, 또한 인생 전반에 걸쳐 느낄 수 있는 특정한 문제점들을 해소할 수 있게 됩니다. 그러나 상담은 마술이 아니기 때문에, 이러한 변화가 하루아침에 일어나지 않는다는 것을 이해해야 합니다. 본인이 이 상담에 얼마나 적극적으로 참여하는지와 조언을 얼마나 열린 마음으로 받아들이는 지에 따라 상담 참여에 따른 보상이 달라질 것입니다.

## 집단 상담의 가능한 문제점들

집단 표현 상담에 참여하게 되면 몇 가지 불편함을 느낄 수 있습니다. 즐겁지 않았던 상황에 대해 기억하거나, 분노, 두려움, 불안함, 슬픔, 좌절, 외로움, 절망감, 또는 다른 원치 않는 감정들을 경험할 수 있습니다. 만약 상담 도중 이러한 스트레스성 감정이 생긴다면, 언제든지 집단 구성원이나 저(집단상담사)에게 도움을 요청할 수 있습니다. 표현 상담 중에는 상대 구성원이나 저(집단상담사)을 향한 강한 감정과 반응을 표출하는 것이 정상입니다. 따라서 이해 가능한 여러 가지 감정들은 집단 내의 환경에서 얼마든지 의논하고 진행하실 수 있습니다.

## 응급상황

저(집단상담사)는 업무 시간(월요일부터 금요일까지)에는 언제든지 연락이 되며 972-904-1777 로 전화하시거나 chung@mail.stmarytx.edu 로 이메일을 보내시면 됩니다. 만약 귀하가 응급상황에 처해 있거나 즉각적인 도움이 필요하시다면 '911'로 전화하거나 귀하의 카운티 거주민을 위한 위기대응킵에 연락해야 합니다. 별도의 규정이 없는 한, 저(집단상담사)는 24 시간 이내에 귀하의 전화 메시지에 응답해 드리겠습니다.

## 추천

만약 귀하가 해당 집단상담을 통해 혜택이나 도움을 받지 못하거나, 이 상담 형식으로 제공 할 수 있는 것 보다 더 많은 보살핌이 필요하다고 판단되면, 저(집단상담사)는 귀하와의 상담 관계를 종료하고 다른 상담을 추천해 드릴 것입니다. 귀하는 다른 정신 건강 전문의에게 도움을 받거나, 추천 받은 정신 건강 전문의 중에 귀하가 선택한 정신 건강 전문의에게 상담을 받거나, 또는 상담을 종료할 수도 있습니다. 만약 추천이 필요하다고 느껴지면, 언제든지 저(집단상담사)에게 이야기해 주십시오.

## 참가자 서명

이 내용을 읽기 위해 시간을 내어 집중해주셔서 감사합니다. 참가자 본인은 위 내용을 모두 읽었으며, 질문을 하였고, 상담을 통해 나타날 수 있는 가능한 위험이나 보상 범위, 비밀 보장, 전문 기록 내용들, 그리고 별도의 처우에 대해 이해하였음을 서약합니다.

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Print Group Participant's Name

Date

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Group Participant's Signature

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Print Group Facilitator's Name

Date

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Facilitator's Signature

**APPENDIX O:**  
**INFORMED CONSENT FORM FOR PARTICIPANT IN RESEARCH STUDY-**  
**BACK TRANSLATION KOREAN TO ENGLISH VERSION**

**EXPRESSIVE GROUP COUNSELING CONSENT**  
**Sunkyung Chung, MA, NCC, RPT, LPC (TX 68870)**  
**schung@mail.stmarytx.edu or 972-904-1777**

**Welcome to your group counseling experience!**

The success of group counseling depends on the trust between participants, group members, and your group facilitator. This consent is prepared for you to give information about group counseling and your facilitator.

**Qualification**

I, your group facilitator, have a Master of Arts degree in 'Marriage and family therapy' from St. Mary's University at San Antonio, Texas and am currently studying for a doctoral degree in 'Counselor education and supervision' at same university. I have a professional counseling license (LPC) released from Texas state and registered as professional playing therapist (RPT). I have counseling experience with people from different age from children, adolescent, young adults to old adults in different environment. And I'm currently working on depression, anxiety, sexual trauma, immigration, and women's issue.

**Understanding of group counseling**

The group counseling is to better understand yourself and the people around you. It will give you a chance to observe how you make your relationship with other people and explore patterns of thinking and behaviors in your life. Objectives of group counseling includes,

- Help you to release the stress, difficulties, and unwanted emotions
- Make you to understand the support of other members
- Understand more about yourself
- Able to observe and find your thoughts, emotions, and behaviors.

You have all the rights to decide how much you will share and open yourself to other members in a group. However, the more open you are the more experience you will gain from the counseling. You can ask questions anytime you want to.

### **Comfortable Environment**

The group counseling facilitator and the group members will create comfortable environment. The major factor is the chance to create trust and respect within one another. And other factor is confidentiality. The group facilitator has legal duty to maintain confidentiality. As a group member, you are also bound to keep all the words mentioned from the group counseling. It is welcome for you to share your learning experiences and thoughts about yourself with others. However, you should remember that you are not allowed to talk about other group members and keep the confidentiality of other members in any case.

### **Confidentiality**

It is very important for you to have comfortable mind to speak freely during the group counseling. You may discuss about things that you do not want to open outside because counseling members have the high expectation of privacy in group sessions. Therefore, all the members will be asked to sign for a high level of confidentiality during counseling. It means that all the members will never open any personal information identifying group members to outside the group. You can freely share your personal reaction and emotions that you earn during session. However, talking about other group members is strictly forbidden.

Your privacy is protected by the state regulation. The group facilitator will keep and store all the communication and records confidentially. And facilitator will not discuss the information with anybody outside the group. However, in some cases, due to national regulation and professional ethics, we may require facilitator open your information without telling you. The potential cases are as follows;

- If you are a threat to yourself or others, (with suicide or homicidal intent) we may contact medical or law professionals in order to keep you safe.
- If you make facilitator suspect that physical, emotional, or sexual abuse might occur to minor people such as disabled, elderly person, we would contact Texas Department of Family and Protective (DFPS) to protect the individuals.
- If the court of law orders to open the records or to make facilitator testify about participants, we will first ask to determine whether you want to open the case public. (Records related to certain individual only) If you do not want your records to be opened, we will fight the subpoena. If the judge decides to open the records, we will release it only to the judge.
- Records may release only when you request. Records will include only your own individual information, not any of the others. Counseling notes do not include research data.
- The facilitator can discuss the interactions inside the group with the faculty professors, or with dissertation committee. This will make me to have better perspective and ideas to help participants. Even though we make any discussion, the privacy of the group members would not be released.

- You must be aware that information through e-mail or cell phone communications might not be protected. Even though my personal e-mail account is secured, your e-mail account may store your interaction, or mobile phone conversation can be also viewed. Therefore, you should understand that communications between you and the facilitator might not be protected when you sign this consent.

All data will be kept for 5 years after the last counseling session. After that, it will be disposed within a legal and confidential manner. If the facilitator is not able to practice the disposal, the faculty supervisor Dr. Melanie C. Harper, LPC-S will be assigned to do all the action. If you have any question, you may call 21-438-6400, or can e-mail mharper@stmarytx.edu.

### **Rights and responsibility of the client**

As a client, you have the right to end the counseling relationship at anytime. And if you believe any counseling techniques or suggestions is harmful to yourself, you can refuse to continue counseling or discuss about those feelings. You should come to group counseling without taking any drugs and alcohol. The facilitator also has the right to terminate the counseling relationship if I believe it is in your best interest. We assure you that all your counseling is performed in a professional manner within legal, and ethical standards.

### **Complaints**

If you feel dissatisfied with our counseling, please let us know anytime. If I am not able to solve your concern or if you need further assistance, please contact my faculty advisor, Dr. Melanie C. Harper, LPC-S (210-438-6400 or mharper@stmarytx.edu). You can also submit a complaint to the Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only. If you choose to file a complaint, I will not retaliate in.

### **Fee**

This counseling is free of charge.

### **Consistent Attendance**

During counseling, your consistent attendance is very important. These will create environment which can make your group grow and change. If you are absent, it can affect experiences of you and your group members. Therefore, we ask you to attend the counseling meetings consistently with a top priority. However, you may have emergent situation. If you are absent from the group due to any emergency or sudden illness, please let us know first.

**Potential benefits of group counseling**

If you participate in this group counseling, you will be able to get few benefits. First, you can understand your value and objectives better, improve your personal relationships, and can solve specific problems which will happen during your life time. However, you should understand that counseling is not a magic, so these changes do not occur overnight. The benefits are depended on your willingness to participate and your oneness to take feedback from the group counseling.

**Potential risks of group counseling**

You can feel few uncomfortable feelings while participating in group counseling. You may remember unhappy situations, and can experience anger, fear, anxiety, sadness, frustration, loneliness, wimpishness, and other unwanted emotions. If you feel any of these stressful thoughts, you can discuss them with group members and facilitator. It is normal to feel intense feelings and reactions to other group members and facilitator during the counseling. Therefore, these emotions are understandable and can be discussed and processed in a session.

**Emergency**

You can always call me in business time from Mon. to Fri. at 972-904-1777 or email [schung@mail.stmarytx.edu](mailto:schung@mail.stmarytx.edu). If you can't contact me and you feel emergent, you should call '911' or crisis response team near your residency. Unless otherwise specified, I will return phone messages within 24 hours.

**Transfer**

If you do not get any help from our group counseling, or we think you need other form of counseling, we will terminate the counseling relationship and transfer you to other agency. You may get help from other mental health professional, or you may choose your own mental health agency. And you can also refuse all the counseling. If you need any other help, please let us know.



**Signature of group participant**

Thank you for your time reading this document with attention.

I have read all the information in this document, and have asked questions, and understood potential risks and benefit of the counseling, confidentiality, professional records data, and alternative treatments.

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Print Group Participant's Name

Date

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Group Participant's Signature

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Print Group Facilitator's Name

Date

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Facilitator's Signature

## APPENDIX P:

### A JOURNEY OF A THOUSAND MILES

(Four sessions curriculum is designed to take place twice a week for one and half hours)

Session One: "Just a Feeling: Beginning Your Journey"	
Materials	<ul style="list-style-type: none"> <li>• Korean traditional and classic music <i>Gugak</i></li> </ul>
Art supplies	<ul style="list-style-type: none"> <li>• Various craft masks (e.g. animals, humane, traditional Korean masks), crayon, acrylic, paint, painting brushes, plastic plates for paints, plastic cups for water, color papers, construction paper, scissors, gules, glue guns, glue gun sticks, glitter, beads, sheet of papers, color pens, markers, color pencils, ribbons, art tapes fabrics, wood sticks, features, color felts, acrylic yarns, magazines etc.</li> </ul>
Complimentary	<ul style="list-style-type: none"> <li>• Alcohol free beverages, bottle waters, cookies</li> </ul>
Goals	<ul style="list-style-type: none"> <li>• To explore feelings in the present moment of dealing with adjusting to living in the United States through arts</li> <li>• To become aware of own feeling and learn how to use art as a coping skill.</li> <li>• To create empathetic and supportive relationship</li> </ul>
Part One	<p>Check in: 20 to 30 minutes</p> <ul style="list-style-type: none"> <li>• Completing research study consent form</li> <li>• Completing pre-measurements surveys (the demographic questionnaire, the Acculturative Stress Index (ASI), and the Center for Epidemiological Studies Depression (CES-D) scale</li> </ul>
Part Two	<p>Introduction: 20 minutes</p> <ul style="list-style-type: none"> <li>• Brief introduction of facilitator and group members for welcoming everyone</li> <li>• Brief introducing the concept of expressive arts interventions and not to focus artistic productive work</li> <li>• Reminding the group rules and agreement</li> <li>• Brief mindfulness meditation for opening</li> </ul>
Part Three	<p>Activity: 30 to 40 minutes</p> <p>Creating a mask</p> <ul style="list-style-type: none"> <li>• Have a discussion about experience living in the United States and acculturative stress</li> <li>• Ask to clients to select or choose a mask what they want to work with and any art supplies what you want to use to decorate the mask</li> <li>• Start to create and decorate the mask with them choose of art supplies what they like to use</li> <li>• "Please take time to know how you feel and what you think before you start"</li> <li>• After clients define their emotion, please ask to express their feeling in the present moment regarding while adjusting to living in the United States on the mask</li> <li>• Clients may think it is not easy project or may not know how to start, please let the clients know that it is fine we all may feel like same. Just recommend taking time and they can slowly start.</li> <li>• "If you need help please let me know"</li> <li>• After the clients create their mask, ask to take a piece of paper and write a poem or letter reflecting on their emotions, experiences, changes or thoughts while creating their mask.</li> </ul>
Part Four	<ul style="list-style-type: none"> <li>• Closing: 20 to 30 minutes</li> <li>• Group discussion and sharing</li> <li>• Brief mindfulness meditation for closing</li> <li>• Closing session</li> </ul>

Session Two: "The Simple Path of Your Journey"	
Materials	<ul style="list-style-type: none"> <li>• Korean traditional and classic music <i>Gugak</i></li> <li>• Rectangular clear plastic boxes with blue lids. The boxes are 12 by 8.5 inches and 3 inches deep, and the blue lids will be placed under the boxes to create a blue colored bottom</li> <li>• Play sand</li> <li>• Miniatures including variety of people figures (i.e. different ethnic family groups, adults, children, occupational, historical figures, brides and grooms), animals figures (i.e. dinosaurs, lions, bears, cows, dogs, cats, insect, and sea life), buildings figures (i.e. churches, temples, hospitals, castles, teepees, and school), transportation figures (i.e. cars, flights, boats, wagon, and Cinderella-types coach), trees, flowers, fences, gates, signs, natural items (i.e. sea shells, rocks, and fossils), fantasy figures (i.e. magical figures, monsters, mermaid, and movies characters), spiritual figures ( i.e. pastors, angel, Buddha, crystals, and gold), house hold items (i.e. furniture, tools, dishes, beer, and food), medical items, drug/alcohol items, and cultural represented figures, especially, Korean and Asian cultural items</li> </ul>
Art supplies	<ul style="list-style-type: none"> <li>• Papers, crayon, color pens, markers, color pencils</li> </ul>
Complimentary	<ul style="list-style-type: none"> <li>• Alcohol free beverages, bottle waters, cookies</li> </ul>
Goals	<ul style="list-style-type: none"> <li>• To gain empathy and understanding for each members' unique experiences with distress</li> <li>• To understand importance of self-awareness, self-actualization, self-expression, self-directed growth and healing</li> <li>• To obtain how to express their feeling and thoughts without any judgment</li> </ul>
Part One	<p>Check in: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Share about anything that has come up over the past week, including their experience of the prior week, feelings, thoughts, beliefs, difficulties or challenges</li> <li>• Brief reminding the group rules and agreement</li> <li>• Brief mindfulness meditation for opening</li> </ul>
Part Two	<p>Activity: 40 to 60 minutes</p> <ul style="list-style-type: none"> <li>• Brief introduce the sandtray and provide basic sandtray instructions to the group members</li> <li>• "Please use the rectangular clear plastic boxes with blue lids in front of you as your sandtray"</li> <li>• Ask clients to create and build the world that you lived in before they moved to the United States.</li> <li>• Ask clients to take time to look all the figures and miniatures what they want and feel free to use any figures and miniatures to build your world.</li> <li>• After clients created and built the world that they lived in before they moved to the United States</li> <li>• "I want to ask you to write about your emotions, experiences, or thoughts while building your world"</li> <li>• "Now, I want you to build a second world, the world in which the currently live"</li> <li>• "Like previously, take time to look all the figures and miniatures what you want to you and feel free to use any figures and miniatures to build your world"</li> <li>• After clients completely build this world, ask clients to write a poem or letter reflecting on their emotions, experiences, or thoughts while building her world</li> </ul>
Part Three	<p>Closing: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Group discussion and sharing about their experiences of the sandtray activity</li> <li>• Inform and explain to the group that the sandtray therapy activity may stimulate various emotions and thoughts</li> <li>• Suggest the group to write about these emotions and thoughts during the week as they reflect on this activity and bring those writings to the next group session</li> <li>• Brief mindfulness meditation for closing</li> <li>• Closing session</li> </ul>

Session Three: "In Peace with Your Journey"	
Materials	<ul style="list-style-type: none"> <li>• Korean traditional relaxation music</li> <li>• Yoga mats, blankets, and cushions to provide safe environment for the group</li> </ul>
Art supplies	<ul style="list-style-type: none"> <li>• Drawing paper, various sizes of bowls that they can use to help them draw one or more circles on the paper, and art supplies (e.g. color pencils, markers, and crayons)</li> </ul>
Complimentary	<ul style="list-style-type: none"> <li>• Alcohol free beverages, bottle waters, cookies</li> </ul>
Goals	<ul style="list-style-type: none"> <li>• To learn self-awareness, self-actualization, self-expression, self-directed growth and healing</li> <li>• To build effective coping strategies to decrease acculturative stress and depressive symptoms</li> </ul>
Part One	<p>Check in: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Check in: Share about anything that has come up over the past week, including their experience of the prior week, feelings, thoughts, beliefs, difficulties or challenges</li> <li>• Brief reminding the group rules and agreement</li> </ul>
Part Two	<p>Activity: 40 to 60 minutes</p> <ul style="list-style-type: none"> <li>• Suggest to the group members to work bare foot to improve the experiential quality of the activities</li> <li>• Instruct to begin to walk around room and focus on their whole body</li> <li>• Ask to relax their body and drop the tension in neck or shoulder</li> <li>• Invite to sit or lay down on the floor</li> <li>• Guide to imagine themselves in a calm, peaceful, and relaxed place while paying attention to their own deep breathing</li> <li>• Create your own story in their mind with peaceful images, which will help them to be relaxed</li> <li>• Mindfulness mandalas</li> <li>• Create mandalas with how they feel now</li> <li>• Be encouraged not to talk and to listen to the relaxation music that helps to clean their minds and thoughts</li> </ul>
Part Three	<p>Closing: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Briefly go around and share their experience with other group members</li> <li>• Group discussion and sharing about their experiences in participating in the meditation and in creating the mandalas</li> <li>• Brief mindfulness meditation for closing</li> <li>• Recommend that they can decide to take finished mandalas to home after forth session, which was the last session of this group</li> <li>• Closing session</li> </ul>

Session Four: "Healing and Celebrating in Your Journey"	
Materials	<ul style="list-style-type: none"> <li>• Sogo: traditional Korean hand drums</li> <li>• Korean traditional music including slow, medium, and fast tempos</li> <li>• Korean traditional and classic music <i>Gugak</i></li> </ul>
Art supplies	<ul style="list-style-type: none"> <li>• 8 by 10 canvas panels, crayon, acrylic paint, painting brushes, plastic plates for paints, plastic cups for water, color papers, construction paper, scissors, gules, glue guns, glue gun sticks, glitter, beads, sheet of papers, color pens, markers, color pencils, ribbons, art tapes fabrics, wood sticks, features, color felts, acrylic yarns, magazines etc</li> </ul>
Complimentary	<ul style="list-style-type: none"> <li>• Alcohol free beverages, bottle waters, cookies</li> </ul>
Goals	<ul style="list-style-type: none"> <li>• To focus on the present and understand what is really happening in right now</li> <li>• To build effective coping strategies to decrease acculturative stress and depressive symptoms</li> <li>• To understand transition and ending in the life</li> </ul>
Part One	<p>Check in: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Check in: Share about anything that has come up over the past week, including their experience of the prior week, feelings, thoughts, beliefs, difficulties or challenges</li> <li>• Brief reminding the group rules and agreement</li> <li>• Brief mindfulness meditation for opening</li> </ul>
Part Two	<p>Activity: 40 to 60 minutes</p> <ul style="list-style-type: none"> <li>• First Activities: Sogo drumming dance <ul style="list-style-type: none"> <li>a. Briefly introduces the Sogo drumming dance</li> <li>b. Demonstrate basic Sogo drumming beat and rhythms</li> <li>c. Demonstrate basic Sogo movement as a dance</li> <li>d. Invite the group to follow the facilitator's performance</li> <li>e. "If feel uncomfortable, you can wear the mask that you created in the first session"</li> </ul> </li> <li>• Suggest the group to play the drum with whatever beat and dance however they want to move</li> <li>• Ask the group if anyone is willing to lead drumming and dancing for the whole group and the other group members will follow</li> <li>• Take 10 minutes break to calm down and relax. During the break, the group members will have drinks and snacks to prevent any dehydration</li> <li>• Second activities: Drawing a tree <ul style="list-style-type: none"> <li>a. Ask to have a seat in a circle</li> <li>b. Draw a tree with acrylic paints on that represent who they are now</li> <li>c. Write a statement, a poem, or letter regarding their healing journey on the back of the panel</li> </ul> </li> </ul>
Part Three	<p>Closing: 10 to 15 minutes</p> <ul style="list-style-type: none"> <li>• Briefly go around and share their experience with other group members</li> <li>• Group discussion and sharing about their trees and experiences in playing drum and dancing.</li> <li>• Discusses and explore the possible and potential issues of termination</li> <li>• Suggestion and recommendation</li> <li>• Brief mindfulness meditation for closing</li> <li>• Closing session</li> </ul>

## CURRICULUM VITA

**Sunkyung Chung, M.A., NCC, RPT, LPC**

[sunkvung1@gmail.com](mailto:sunkvung1@gmail.com)

### EDUCATIONAL HISTORY

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<p><b>St. Mary's University</b> Ph. D., Counselor Education and Supervision (CACREP)</p>	<p>San Antonio, Texas Anticipated December 2018</p>
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Concentrations: Marriage and Family Therapy and Play Therapy

<p><b>St. Mary's University</b> San Antonio, TX M. A., Marriage and Family Therapy (COAMFTE)</p>	<p>San Antonio, Texas December 2009</p>
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<p><b>West Texas A&amp;M University</b> B. A., Business Administration in Accounting</p>	<p>Canyon, Texas May 2005</p>
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### LICENSE AND CERTIFICATION

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Licensed Professional Counselor (LPC) in Texas  
National Certified Counselor (NCC)  
Registered Play Therapist (RPT)  
Eye Movement Desensitization and Reprocessing (EMDR) Basic Training Certification  
Hypnosis and hypnotherapy Certification  
Gottman Method Couples Therapy Level: Bridging the Couple Chasm Certification  
Integral Breath therapy level one certification

### ADDITIONAL TRAINING

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|---|-----------------------------|
| <ul style="list-style-type: none"> <li>• Trained certified sexual assault training program of Sexual Assault Prevention and Crisis Services (SAPCS) by Crime Victim Services Division of the Office of the Attorney General.</li> </ul> | <p>2015</p>                 |
| <ul style="list-style-type: none"> <li>• Trained trauma informed care</li> </ul>  | <p>2013</p>                 |
| <ul style="list-style-type: none"> <li>• Trained AASECT certified sex therapists</li> </ul>   | <p>from 2012 to present</p> |
| <ul style="list-style-type: none"> <li>• Trained relational-cultural therapy</li> </ul>   | <p>from 2009 to 2011</p>    |

### TEACHING AND MENTORING EXPERIENCE

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| <ul style="list-style-type: none"> <li>• <b>Teaching Assistant</b><br/>Introduction of counseling theories<br/>Advanced child development</li> </ul> | <p>Fall 2012<br/>from 2010 to 2012</p> |
| <ul style="list-style-type: none"> <li>• <b>Instructor</b><br/>Ethical Aspects of Human Services<br/>Introduction of Human Services</li> </ul>       | <p>Spring 2011<br/>Fall 2010</p>       |

## RESEARCH EXPERIENCE

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### Ph. D. Research

Co-designed and co-conducted quantitative research project on graduate students' self-perceived competence and adequacy of training in play therapy, Fall 2009-Spring 2010

## PUBLICATIONS

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- Mercado, M. & Chung, S. K. (2014). Association for multicultural counseling and development. In L. H. Cousins (Ed.), *Encyclopedia of Human Services and Diversity* (Vol. 1, pp.118-120). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781483346663.n53
- Chung, S. K. (2018, March 2). 뜨거운 감자...미투운동(Me Too Movement). *Korean Journal Houston*, pp. A83.
- Chung, S. K. (2018, March 9). 우울해서 그랬네.... *Korean Journal Houston*, p. A83.
- Chung, S. K. (2018, March 16). 악몽의 크리스마스. *Korean Journal Houston*, p. A83.
- Chung, S. K. (2018, March 30). 나만의 스트레스 대처법을 찾자. *Korean Journal Houston*, p. A82.

## PRESENTATIONS

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- Chung, S.K., & Hightower, L.A. (2016). *Keep calm and have fun: Creative and expressive group therapy working with women survivors of sexual abuse*. Texas Counseling Association, Dallas, Texas.
- Hightower, L. A, & Chung, S. K. (2016). *Vamos a Jugar: Effective play therapy techniques for working with minority children*. Texas Counseling Association, Dallas, Texas.
- Chung, S. K. (2016). *Wake-up call: Child sexual violence (Understanding and identifying child sexual abuse and supporting survivors)*. Our Lady of Lake, San Antonio, Texas.
- Chung, S. K. (2016). "Dad, you never talked to me about sex;" *The role a father plays in a daughter's sex education*. at Graduate Research Colloquium, San Antonio, Texas
- Chung, S. K. (2014, 2015, 2016). *Self-care and secondary trauma*. Volunteer Training at Rape Crisis Center, San Antonio, Texas.
- Chung, S. K., Dome, M., Herrington, K., & Medellin, E. M. (2014, Fall). *When supervisees knock on your door: Trauma-related supervision for counselors who work with sexual abuse survivors*. Texas Counseling Association, Dallas, Texas.
- Chung, S. K., Dome, M., Herrington, K., & Medellin, E. M. (2013, Winter). *When supervisees knock on your door: Trauma-related supervision for counselors who work with sexual abuse survivors*. Texas Counseling Association, Dallas, Texas.
- Chung, S. K., Mercado, M., Wooten, R., & Atkinson, A. (2013, Fall). *Wading through deep water: Somatic mindfulness for adolescent survivors of childhood sexual abuse*. Texas Counseling Association, San Antonio, Texas
- Chung, S. K., Mercado, M., Reynolds, M. S., & Strentzsch, J. (2013, Fall). "Dad, you never talked to me about sex;" *The role a father plays in a daughter's sex education*. Texas Counseling Association, San Antonio, Texas
- Chung, S. K., Mercado, M., Roeynolds, M.S., & Strentzsch, J. (2013, Summer). *Dad, you never talked to me about sex: The role of father figures play in their daughters' conflicts about sexuality*. American Association of Sexuality Educators, Counselors and Therapists' 45th Annual Conference, Miami, Florida.

- Chung, S. K., & Barron, L. (2013, Spring). *Rewriting my history: Using writing with immigrant students to build self-esteem*. 7th Annual San Antonio Writing Project Conference, San Antonio, Texas
- Chung, S. K., & Barron, L. (2012, Fall). *Asian American culture: Not just "Chinatown" anymore*. Texas Counseling Association, Galveston, Texas.
- Chung, S. K., Delagarza, Monical, P., M., & Romo, L.V. (2010, Fall). *Using puppets in counseling supervision*. Texas Counseling Association, Austin, Texas.

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## CLINICAL EXPERIENCE

### Licensed Professional Counselor (LPC)

The Rape Crisis Center, San Antonio, Texas

May 2014 – Present

### Licensed Professional Counselor Intern (LPC-Intern)

Anchor Marriage and Family Counseling Center

The Rape Crisis Center, San Antonio, Texas

March 2013 – September 2014

October 2012 – March 2014

### Student Intern

Family Life Center, San Antonio, Texas

June 2008 – May 2012

Incarinate Word High School, San Antonio, Texas

August 2009 – May 2010

Family Support Center, Universal City, Texas

August 2008 – May 2010

Schertz-Cibolo-Universal City Independent School District

August 2008 – May 2010

(Dobie Jr. high school & Byron P. Steele II high school), Universal City, Texas

A. Conducted counseling for adolescents both individual and group formats.

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## OTHER PROFESSIONAL EXPERIENCE

### Office Assistant / After School Teacher

Immigrant & Multicultural Family Center, Gasan, South Korea

February - August 2007

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## OTHER SERVICE

### Volunteer Activities

Annual Conference of Down Syndrome Association

2011

Annual Conference of American Association for Marriage and Family Therapy

2011

Annual Conference of American Association for Marriage and Family Therapy

2010

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## HONORS AND AWARDS

Outstanding part-time Counselor at The Rape Crisis Center

2015

Outstanding Volunteer Counselor at The Rape Crisis Center

2014

Nominated for an award through the United Way

2014

Volunteer of the Year Awards Program



**PROFESSIONAL MEMBERSHIPS**

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American Association of Sexuality Educators, Counselors & Therapists

American Counseling Association

Association for Play Therapy

Association for Counselor Education and Supervision

Texas Counselors for Social Justice

Texas Counseling Association