Mental Health Utilization and Stigma in First Generation Older Korean American Adults

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Abstract

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Background. There are numerous barriers to mental health utilization, one of the most widely cited being stigma. Previous literature aggregates different Asian American subgroups into one homogenous group, which does not provide nuanced insight into a specific community's way of conceptualizing mental illnesses or the interventions needed to shift negative attitudes. Furthermore, older, first generation, Korean American adults are a vulnerable and understudied population. This population experiences significant mental health need, while experiencing many barriers to mental health utilization.[1, 2] The purpose of this study is to explore how older, first-generation, Korean American adults conceptualize stigma around mental health and the actions needed to shift the narrative around mental illness. This would result in advancements in mental health research among older Korean Americans. ***Methods.*** This study was conducted in the New York Metropolitan area, in partnership with a local community-based organization. A total of 12 individual, semi-structured interviews were conducted in Korean. Transcripts were directly transcribed into English and two members of the research team checked the transcriptions for

accuracy in translation. Content analysis was used to identify concepts. ***Results.*** From the data, two findings were identified: 1) despite more acceptance towards mental illness, negative perceptions continue to be informed by stereotypes and prejudice, 2) to shift the negative narrative, there is a need for space to dialogue and increase education and awareness surrounding mental health. ***Conclusion.*** Negative mental health perceptions may influence openness to mental health utilization in the Korean American community. However, church can be an accessible space for a mental health program, but careful consideration is needed to avoid the focus shifting away from mental health to faith.

INTRODUCTION

Among all mental illness diagnoses in the general population, depression and anxiety are one of the most common diagnoses in the United States (U.S.), with a lifetime prevalence of 28.8% for anxiety disorders and 20.8% for mood disorders.[3] In comparison, the National Latino and Asian American Study (NLAAS) reports that Asian Americans experience a lifetime prevalence of 9.1% for depressive disorders, compared to 17.9% in non-Latino Whites.[1] There are several factors that may explain this lower lifetime prevalence of depressive disorders in Asian American adults when compared to non-Latino Whites. For example, the NLAAS survey is only translated into Spanish, Tagalog, Vietnamese and Chinese, excluding many other vulnerable, non-English fluent individuals.[1]

Furthermore, cultural beliefs may shape the way Asians conceptualize and experience mental health symptoms.[4] For example, previous studies have shown that Asians tend to somaticize their symptoms rather than describe symptoms psychologically.[5] Consequently, many individuals seek care from primary care providers (PCP). Among Asian Americans experiencing any psychiatric disorder in the previous 12-months, only 8.6% of these individuals accessed help from any services (e.g., PCP, religious leader, social worker) and 3.1% specifically sought help from a mental health provider.[2] This is compared to the general population, which utilizes specialty mental health services at 8.8%.[2] In comparison to other ethnic groups, Asian Americans access specialty mental health services at the lowest rate.[2] Clearly, there is a need for mental health services while there is also an underutilization of services that differs across ethnicity, immigration status, age and generation.[2]

There is considerable heterogeneity regarding mental health service utilization and mental illness prevalence across different Asian American subgroups. In a cross-sectional analysis of a diverse sample of Asian American subgroups**,** researchers found that older adults of all subgroups were less likely to utilize mental health services compared to non-Latino, white, older adults.[6] Younger, US-born, Asian Americans were also more open to seeking mental health treatment from a specialist compared to older, immigrant, Asian American adults.[2,7] This difference between immigrant and US-born Asian Americans might be explained by perceived helpfulness of care.[2] In a study examining service utilization, treatment ratings and diagnosis in immigrant versus US-born Asian American adults, third-generation or later gave higher ratings of perceived helpfulness for any services received.[2] Finally, different Asian American subgroups experience different prevalence levels for mental illnesses and symptoms. In national mortality records in the U.S. from 2003-2011**,** Korean American adults had the highest suicide mortality of any Asian American subgroup.[8] Another study suggests Korean older adults were more likely to endorse symptoms of depression and anxiety among other Asian American groups and less likely to see a primary health care provider for their mental health symptoms.[6,9] This is potentially explained by a lack of awareness for the signs and symptoms of depression.[9] In another study examining knowledge of depression, acculturation level and severity of depression in older Korean American adults, being less acculturated was associated with less knowledge of depression and higher levels of depression.[9] Lacking awareness for early signs of depression could lead to an underutilization of mental health services and exacerbation of symptoms and other health consequences. Older Korean American adults who immigrated to the U.S. are a vulnerable and understudied population and warrant more research given the multitude of barriers to mental health services. There are numerous consequences to unaddressed mental health needs. The

National Comorbidity Survey, a cross-sectional study, examined delays in treatment in first mental health episodes.[10] Researchers found that delays in care can increase morbidity and mortality of mental illnesses, and increase the risk of comorbidities with various physical illnesses.[10] This suggests that mental and physical health are both integral to overall well-being. Another cross-sectional study examined mental illness and onset of physical conditions in 17 countries (e.g., countries in Asia, Latin America, North America).[11] Researchers found that regardless of the severity of mental illness, there was an association between many of the physical condition outcomes (e.g., diabetes mellitus, stroke, arthritis).[11] Clearly, mental and physical well-being are deeply connected. Although these studies don't examine the link between mental health and physical health consequences specifically in older Korean Americans, it still underscores the importance of addressing mental health utilization in this community.

Countless studies cite stigma as an important cultural barrier to mental health utilization in Asian Americans, including Korean American older adults.[3, 12–17] Very few behavioral interventions or strategies exist to reduce mental health stigma. A study that aimed to de-stigmatize mental health beliefs in older Korean adults, reported increased knowledge regarding mental health, but no significant improvements in negative attitudes towards individuals with mental illnesses.[18] In order to shift the narrative from these attitudes specifically within the older, immigrant, Korean American community; it is critical to understand older Korean Americans thoughts and ideas about mental health, mental health services, and stigma in the community. The purpose of this study is to explore how older Korean American adults conceptualize stigma around mental health and the actions needed to shift the narrative of mental illness. Expanding the knowledge

base of these concepts will result in advancements in mental health research among older Korean Americans.

METHODS

Recruitment

The University of Washington research team, led by Dr. Linda Ko, partnered with Asian American Resource and Information Network (AARIN); a community-based organization (CBO) based in the New York metropolitan area. AARIN aims to develop and disseminate research in collaboration with researchers, community stakeholders and other CBOs. AARIN is well-connected with various Asian American serving CBOs and the local Asian American community. Furthermore, AARIN has extensive experience with health promotion and information dissemination initiatives. Recruitment flyers were shared with local CBOs serving the Asian American community and social media (e.g., KakaoTalk, a popular messaging application among Korean Americans) by the community partner. Presentations were also given at local CBOs in Korean to share information about the study. All recruitment materials were translated into Korean.

Setting and Population

Eligibility criteria included self-identification as a Korean person, between ages 50 and 89, with mild to moderate depressive symptoms (PHQ-9 scores from 5-14), self-reported limited English proficiency (responded “less than very well” when asked “how well do you speak English?”), and self-reported native fluency in Korean. Enrollment took place in person, via Zoom and

phone for community-dwelling older adults in the New York metropolitan area. Nineteen individuals were contacted, eighteen participants responded to recruitment materials, and of those individuals, 12 (63%) were eligible and agreed to participate.

Interview Guide and Data Collection

The interview questions were first adapted from quantitative and qualitative questions from the Day Mental Illness Stigma Scale and Stigmatizing Beliefs about Depression measure and a semi-structured interview guide conducted with the Vietnamese refugee community in the Seattle metropolitan area.[19–21] Early iterations of the questionnaire were translated into Korean. Using member-checking, the acceptability, content and understandability of the questions was assessed with the community partner and individuals that identified as older Korean American adults.[22] The interview guide asked mental health perception, stereotypes and prejudice, coping strategies and ways to shift the narrative surrounding mental illness and diagnosis.

The questionnaire was composed of five primary questions with one probe: 1) What are some thoughts, feelings or images that come to mind when you think of someone in your community with a diagnosis of mental illness? 2) Is there a stereotype or prejudice to someone receiving counseling or mental health services in your community? 3) [Probe] What are these stereotypes, prejudice, and discriminatory thoughts? 4) When you are stressed, upset or down, how do you manage your mental well-being? 5) What does your community need to create an environment where conversations around mental health diagnosis occur without attaching stereotypes or prejudice?

Individual interviews lasted between 5-15 minutes and were conducted in Korean. The community partner, who is bicultural and bilingual in Korean and English, conducted the semi-structured interviews assessing mental health stigma. Individual interviews were audio recorded, translated, and transcribed from Korean to English by an experienced translator. Given time constraints, interviews were not transcribed into Korean, and then translated into English. However, previous literature indicates direct transcription and translation is still a robust research method.[23] Two members of the research team checked the transcriptions for accuracy in translation. All transcripts were de-identified to maintain the confidentiality of participants. Materials, measures, and methods were reviewed and approved by the Institutional Review Board of University of Washington.

Data Analysis

Based on the interview guide, a tentative codebook was created deductively.[24] The initial codebook contained nine codes. Deductive coding was used to code transcripts. As there was only one coder, a constant comparative method was used to code interviews.[25] The primary coder selected the richest transcript based on duration and content and coded this transcript with the deductively created codebook. Using this analysis matrix, the primary coder coded the next richest transcript. Each transcript was coded and recoded as the codebook was updated.[25] The final codebook contained 15 codes. Content analysis was then used to identify concepts.[24] In the final stage of analysis, three concepts emerged from the grouping of codes: 1) perceptions of mental health, 2) mental health access, and 3) shifting narratives.

RESULTS

Demographic Characteristics

Participants in this study were older adults (n = 12) mostly women (83%), between the ages of 50 and 89 (M= *65.5*, SD = *9.41*). All participants identified as first-generation immigrants. The average years spent in the U.S. were 30.3 years. All participants reported Korean as their dominant language.

Table 1

Sociodemographic characteristics of participants

Baseline characteristic	**Study**	
	N = 11	%
Gender		
Female	10	90
Male	2	18.1
Marital status		
Single	1	9
Married/partnered	7	63
Divorced/widowed	2	18.1
Other	1	9
Healthcare		
Medicaid/Medicare	6	54.5
Individual	4	36.3
Employer sponsored	1	9

Education		
High school or less	2	18.1
Some college	2	18.1
Associate degree	2	18.1
Bachelors	5	45.5
Household Income		
Less than $15,000	2	18.1
$15,000 to less than $35,000	4	36.4
$35,000 to less than $50,000	0	0
$50,000 to less than $75,000	1	9
$75,000 to less than $100,000	2	18.1
$100,000 to less than $150,000	1	9
$150,000 or more	1	9
English Proficiency		
Not at all	1	9
Not well	8	72.7
Well	2	18.1

Note. *N* = 11, missing sociodemographic data for one participant

Findings

Perceptions of mental health

Nearly all participants shared that there were negative perceptions of mental illness and diagnoses in the community. Many participants talked about the negative attitudes associated with individuals with mental illnesses in the community. Labels include "incomplete", "impulsive", "strange", and "lacking". One individual asked whether mental illness was curable and a couple of participants discussed safety concerns for themselves and for the individual experiencing mental illness. Several participants discussed the blame that is placed on a mentally ill individual in the community. For instance, one participant discussed the tendency for the community to think mental illness is caused by an individual's personality. This participant said,

> "There is a tendency [in the community] to consider the cause of people's difficulties as personal issues…that [mental illness] is part of the personality of a person, I think that may be prejudices." **– *Female participant, age unknown***

Another participant mentioned the inability to motivate themselves to overcome mental illness.

> "I cannot understand why they cannot do it themselves, it cannot be solved by other people, but it seems like they lack the motivation to take it upon themselves. Like, when you feel like something is wrong, then you try to fix it yourself, I am wondering if they lack some of that." **– *Female participant, 70***

Two participants noted the community's reservations towards utilizing mental health services.

> "When I suggest to my friends who seem mentally anxious to receive counseling, they really dislike that I made that suggestion. So, it made me feel that maybe it is not something that I can easily recommend." **– *Female participant, 63***

Two participants also shared that some individuals may try to hide their illness due to community stigma.

> "If you have a diagnosis or experience related to mental health, it can be internalized [meaning by the person with the diagnosis] as being at a disadvantage at a workplace or being looked at as a weakness when a person is seeking employment. But I don't have enough knowledge to discern if that's actually the case or not, and because people don't know how the information is being used in the society, people try hiding it first." - ***Female participant, 63***

Another participant observed that individual with mental illnesses might not participate in programs.

> "People who are mentally struggling need to reflect on their own state, participate in programs, will need to want to change, and take on a positive attitude to try to change themselves. Will they get better just by taking medication? It's not something that will change by giving people advice, to change people's thoughts. And because people are not able to examine themselves, that's why it's a mental problem…
>
> Especially for Koreans, as you know, they do not have affinity for participating in those programs, right? If groups are created, and lots of people participate, then they will be able to free themselves, but for example, if there are groups like this, and if someone is just staying home with their three meals a day, and there is suggestion for them to join, they will not join. At best, I am not sure if they will even go to church, maybe they don't go to places other than to a supermarket. But if they participate in a group with other

people who are similar to them, it would alleviate their mental problems to some extent." ***– Female participant, 70***

Negative perceptions of mental health were composed of stereotypes and prejudice. Most individuals agreed the existence of stereotypes and prejudice the Korean community has towards individuals with mental illness. Few expressed holding stereotypes/prejudice beliefs themselves, even actively denying prejudice. A couple of individuals were unsure whether there were any stereotypes or prejudice present in the community, and said perceptions have changed somewhat. One individual said,

> "Nowadays, it seems to have disappeared a lot. Yes, I think it has disappeared a lot. Back at the thick of coronavirus pandemic, there were many people with depression even students, right? And there were some moms who talked comfortably about what their children were going through and that they were looking for counselors. So, it doesn't seem like how it was in the past" **– *Female participant, 57***

Others shared more acceptance for an individual with a mental illness. One participant said they were "more accepting and less resistant" to a person they've gotten to know who was diagnosed with a mental illness. Another participant indicated it was "fortunate" individuals are seeking treatment and diagnoses.

> "It's unfortunate [meaning the mental illness], but I think it's fortunate that they are seeking diagnosis and treatment." **– *Female participant, 57***

Participants mentioned it was "unfortunate" that others experienced mental illnesses. As an immigrant, a participant stated there was nothing that could be done except to "accept such

issues." In summary, most discussed mental illness in the community from a negative light. What was coded as positive was closer to acceptance and resignation.

Mental health access

Participants discussed their personal and interpersonal experiences with mental illness. Half of the participants cited knowing an individual with a mental health diagnosis or experiencing mental health symptoms. Limited social support, isolation, and loneliness was cited as factors that can worsen symptoms, while another individual noted that the inability to navigate systems in the U.S. as an immigrant contributed to worsening symptoms. Several also shared personal experiences with some degree of emotional distress. A participant mentioned they received inadequate support from their PCP for their symptoms.

Participants discussed both maladaptive and adaptive coping strategies they employed to manage their negative emotions. Maladaptive coping strategies include drinking, throwing objects and social isolation. One individual pointed out their tendency to take responsibility for their stress, which resulted in social isolation. This individual stated,

> "It's been tough at work. Oh no, it's not the work, relationships at work became a bit difficult, and because my personality tends to put the blame on myself, I was under a lot of stress. Because I was taking all the responsibility upon myself, and I have a syndrome of being the "nice one", and I don't like to complain to others, so the stress builds up… sometimes I self-blame. I feel guilty for not reacting maturely. I also wonder why I can't handle it in a good way." **– *Female participant, 57***

Adaptive strategies included social connectedness, engaging in enjoyable distractions (e.g., exercise, walks, reading, nature), deep breathing, sleep, and faith. Further, individuals also cited faith (e.g., prayer, hymns) or reading Buddhist books. A couple of participants shared that their symptoms became "too much to handle" or "the stress builds up" despite their efforts to manage. One participant observed that it was counterproductive for someone experiencing depressive symptoms to be alone, and another indicated that receiving social support may alleviate symptoms when it's addressed early.

> "If this was about me, to make it brief, I am living alone. [I: Right]. As I am living alone, when depression comes, it is serious, and what I can do by myself? As I know that it's not good to be alone, I make every effort to go out, I volunteer and socialize with people, I interact with others a lot, and that's very important." **– *Male participant, 57***

> "I received a lot of support from my friends, which helped me alleviate many symptoms and as someone who has received help, I feel sorry for those whose situation has deteriorated to the point of being diagnosed with a mental disorder. So, when people get to that point, to the point of needing professional help, I can't be of much help, right? [I: Right]. If the symptoms weren't severe, we could have supported each other and helped release it [meaning stress], and if it was a situation that help–will work, it would have been good, but hearing that a situation worsened to the point of a mental disorder diagnosis, I feel sad." **– *Female participant, 53***

In response to existing mental health needs, participants discussed the barriers and facilitators to mental health access in the Korean community. Several participants cited limited social support, limited availability, and inaccessibility of mental health programs outside of community organizations, such as church and limited resources in general. Participants indicated not speaking English and another participant shared that being an immigrant created difficulties in navigating the U.S. and find programs. While some noted church as a way to increase accessibility of programs, others said that church was an inadequate place for mental health access. Some shared that their friends or themselves had reservations about seeking support from other friends or professional services.

> "When I look at people who are aging, older than me, since their social network is shrinking gradually, [I: Yes], they look lonely, but besides church, they have no opportunity to build new relationships, because they don't have opportunities to participate in the community. [I: Ahhhhh]. It is regrettable. If they were in Korea, there would be many gatherings for them to participate." **– *Female participant, 62***

Another important point that participants raised was the need for spaces, programs and groups in which individuals can discuss mental well-being, increase awareness and education about mental illnesses and receive general support to facilitate mental health access. Discussions around supporting other individuals experiencing distress were also expressed by participants. One individual discussed their relationship with an individual with mental illness, and how that has contributed to destigmatizing their prejudice views.

Shifting narratives

Participants indicated it was important there were more education, information, and counseling to increase awareness and shift the perspective that mental illness was an individual problem to a bigger societal issue. While one individual noted that there was nothing that could be done as, "this isn't my country," meaning that they felt like foreigners living in the U.S. as immigrants. One participant mentioned that the community needed to use specialized terminology to refer to mental illness to reduce stigma; while another observed that language and living in a foreign country were major barriers to shifting narratives;

> "Using more specialized terms, such as schizophrenia, instead of the word "mental illness." Also, instead of using the term "mental illness," it would be better to say "early stage of depression." Don't say mentally ill. It has been said that using more appropriate terms such as "behavioral and cognitive disorders" instead of "mentally ill" can be effective in clarifying misunderstandings." **– *Male participant, 57***

Participants also indicated the need for space, opportunity, and groups to offer programs like the Mindfulness Based Cognitive Therapy (MBCT) intervention or spaces for dialogue, although there was disagreement about what this would look like. One participant had some reservations about churches; while she shared that providing health programs at large churches would be accessible to many, she also cautioned of the focus potentially shifting to faith.

"Community organizations should continue to offer such programs, and the approach should not be narrow or limited to specific institutions or volunteer centers….they can also be done in large churches that are easily accessible to the public." However, this could also lead to an emphasis on faith rather than mental health." - ***Female participant, 70***

DISCUSSION

This qualitative study examined how older Korean American adults conceptualize stigma around mental health and the actions needed to shift this narrative. The study found that despite the shift towards more acceptance of mental illnesses, diagnoses and services, participants noted that negative perceptions about mental health in the community influenced mental health service utilization. When participants discussed the Korean communities' perceptions about mental illness, they frequently shared negative perceptions. There is a necessity for space to dialogue openly, increase mental health education and awareness in the Korean American community.

A recurrent perception was that mental illness is due to an individual's personality, a "weak will" or "weak faith". Furthermore, the emphasis on personal responsibility and self-sufficiency was shared by a couple of participants. This value is potentially rooted in communities beliefs about the importance of "self-reliance" as the participants were older and may have experience many historical events (e.g., War World 2, Japanese Colonization, Korean War) where survival was the priority.[26] Negative mental health perceptions continue to influence mental health utilization, especially when the locus of responsibility is placed on the individual, which worsens the stigmatization of mental health diagnoses and service utilization.[27] This idea might be influenced by collectivism, where an individual is considered a reflection of one's family.[28] Due to this,

there may be feelings of shame associated with allowing others to know about one's mental illness and personal struggles, leading to low service utilization.[28, 29] Despite these negative mental health perceptions, participants were open to increasing their own awareness and education about mental health through programs.

This study also found that more accessible spaces are needed to dialogue openly about mental well-being, increase awareness and education. Participants indicated a need for all individuals, regardless of mental health symptoms, to have a space focused on mental well-being. Some participants noted that church might be a good place to consider for increasing accessibility to mental health services. Past literature indicates the importance of faith in social connectedness and maintaining cultural identities, particularly in the Korean American community.[30] Furthermore, churches are a common gathering space for Korean Americans.[30] Therefore, church spaces are already accessible places where community conversations can take place. The importance of community conversations in shifting the narrative on mental health is supported by existing research that indicates its potential to reduce self-reported stigma.[31] If mental health programs are embedded in organizations where their mission is rooted in faith, then program planners should consider grounding the program in mental health. This will enable for participants to receive the full benefits of a mental health program, rather than creating a program packaged as mental health with a central focus on faith.

Strengths and Limitations

There are several limitations to this study. First, stigma is a multifaceted construct and data were captured using five questions on mental health perception, stereotypes and prejudice, coping strategies and shifting the narrative. Therefore, this might not have fully captured all aspects of

stigma. Second, data collection occurred when participants were being screened for eligibility to participate in a mindfulness program. Participants may have given an answer that was socially desirable if they felt that the research team was looking for certain answers. Third, selection bias may have occurred, since participants self-selected themselves to participate in the mindfulness program and they may have held more open views on mental health. Finally, we had a small sample size with the majority of our participants being female (83%) with college-level education (81%). Therefore, these findings from this study cannot be generalizable to other older Korean American adults.

There are several strengths to this study. Past literature has a tendency to aggregate Asian Americans subgroups into one homogenous group. This study specifically focuses on older, first-generation, Korean American adults, which is an understudied population. Furthermore, this study collaborated closely with a community partner throughout the entire research process. It was crucial for the research team to connect with a local community partner to engage with the Asian American community. Past literature indicates that solutions driven by the community and led by community organizations are necessary to shifting the conversation on mental health stigma.[31] Finally, prior studies widely cite stigma as a major barrier to mental health utilization and explore specific stigmatizing beliefs. However, this study adds to the literature by exploring suggestions from the Korean American community on shifting this narrative.

CONCLUSIONS

This study expanded our understanding of how some older Korean American adults conceptualize mental health stigma. It provided an overview on current beliefs about mental

health, and participants shared some suggestions on how to shift this narrative. Future directions can include developing outreach programs in partnership with community health workers or CBOs since previous research has shown some effectiveness towards this.[15]

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