Absolute Solitude of the Alien Mind

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Abstract

The study adopted phenomenology in an attempt to document genuine and authentic accounts from Korean-New Zealanders who had experienced psychological distress and utilised relevant mental health support systems. Most available studies on Korean immigrants' mental health issues have been conducted in the US, and there is relatively little research on Korean-New Zealanders' experience of psychological difficulties. The study found that among the various and well-known challenges an immigration process usually entails feelings of loneliness, alienation, and isolation in particular triggered a degenerated state of mental health in Korean-New Zealanders. The study also found that contrary to the findings of previous studies, stigma and discrimination supposedly attached to mental ill-health did not play a major role in deterring Korean-New Zealanders from accessing and utilising relevant mental health services. Instead, knowledge about mental health and ill-health and information about available service facilities were found to be more pertinent in the utilisation of relevant professional help in a timely manner.

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Chapter 1:   Introduction

1.1   Mental Languages

All language reflects the prejudices of the society in which it evolved

-Casey Millen

When Australia-born singer Olivia Newton-John sang: "Let's get physical", I doubt the popularity of the song was due to people's eagerness to fall physically ill. Perhaps because I am a recent immigrant in New Zealand whose English skills are still quite limited—I can recall only a few incidents when people said, "she has a physical illness", to imply that the person being talked about had, for example, the flu or cancer. Rather, they chose to refer directly to the names of illnesses, saying, "he has the flu" or "she suffered from breast cancer". Sometimes I hear people describing someone as 'mental'. I assume someone who is described as 'physical' will be a person who is either an athlete or participates in a number of sports activities. If so, I would assume that someone who is described as 'mental' will be a person who is creative, intelligent, academic, or sensitive and susceptible. It would only be logical to assume this, as 'physical' refers to the body, while 'mental' refers to the mind or a psychological state.

However, describing someone as 'mental' usually comes with a hand gesture, which involves a finger or a hand drawing a small circle around a head area. Thanks to the accompanying hand gesture, I realised that someone who is referred to as 'mental' has a 'mental illness' and is often seen as abnormal and strange.

1.2 Korean-New Zealanders in a Multi-Cultural Society

There is no subject too old that something new cannot be said about it

- Fyodor Mikhailovich Dostoyevsky

The study was initially inspired by the usage of the English word, 'mental', which was—supposed to be—a technical and neutral linguistic element functioning as an adjective of 'mind'. It seemed that in New Zealand, as one of the Western societies, the word 'mental' had a rather derogatory and stigmatising connotation. It is often believed that Korean culture, as a part of 'Asian' culture, would bear an even stronger stigma and discrimination against someone or an illness classified as 'mental'. A well-documented 'under-utilisation' of mental health services among Korean immigrants is often explained from the 'multi-cultural' perspective (Akutsu, Tsuru, & Chu, 2004; Akutsu, Snowden, & Organista, 1996; Atkinson & Gim RH., 1989; Brown et al., 2003; Chandras, Eddy, & Spaulding, 2000; Chang SY & Myers, 1997; Constantine et al., 2004; Heah, 1998; Kim MY, 1994; Kim BS, Ng, & Ahn, 2005; Lee & Darnell, 2002; Shin JK., 2002; Sue & Sue, 1987; Tracey, Leong, & Glidden, 1986; Watari & Gatz, 2004; Yamashiro & Matsuoka, 1997; Yoo YG, 2002; summed by Zane et al., 1994). Korean immigrants are seen to be reluctant to access relevant mental health services because it is believed they fear the stigma attached to mental illness. Korean people are also claimed to be self-contained and strong-willed as the people and the culture of Korea is influenced by the famous 'Oriental' philosophies such as Buddhism, and Taoism and the teachings of Confucious (Bae SH, Joo & Orlinsky, 2003; Chandras et al., 2000; Chang SY & Myers, 1997; Donnelly, 2001; Ho, Rasheed, & Rasheed, 2004; Kim BS., Ng, & Ahn, 2005; Kim BS et al., 2001; Okazaki, 1997; Purnell & Kim, 2003; Watari & Gatz, 2004; Yoo, YG, 2002). Other plausible explanations would suggest that Korean immigrants are

under-represented in service utilisation because mainstream health providers and professionals fail to deliver culture-sensitive services to the clients from 'other' cultural, linguistic, and ethnic background (Chandras et al., 2000; Donnelly, 2001; Kim MY, 1994; Shin SK, 2004; Shin SK. & Lukens, 2002; Tseng, 2004; Won et al., 2004; Yeh & Inose, 2002).

Such multi-culturalistic perspectives on Korean immigrants' experience of psychological distress and related curing or help-seeking behaviour seem to acknowledge the challenging nature of an immigration process and the resulting risk to mental health and wellbeing. However, due to, amongst other reasons, the short history of immigration by Koreans to New Zealanders, most of the research on the issue of Korean mental ill-health is based on Western countries other than New Zealand. There is not much research on Korean-New Zealanders' experience of psychological and mental instability and insecurity and what research there is, is often included as a part of 'Asian' studies. Therefore, mental health professionals, practitioners, service managers, policymakers, and academics would have no other choice than to rely on research conducted either on Korean immigrants in other Western countries or on Korean-New Zealanders as a part of an entire Asian immigration population in New Zealand.

The immigration experiences of Korean-New Zealanders may not be less difficult than those of Korean immigrants in other countries. Although not regarded as regulars in mental health services, Korean-New Zealanders may have their own share of psychologically distressing issues that may or may not be identical to those of other Asian populations in New Zealand. Therefore, the study aims to investigate the first-hand experiences of Korean-New Zealanders who encountered mental health issues while they were adjusting to and settling down in New Zealand society. By

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providing authentic accounts of Korean-New Zealanders' experiences of psychological distress, the study further hopes to contribute to activities aimed at empowering potential Korean-New Zealander clients who can benefit from the mainstream mental health supporting system. The findings of the study may also contribute to designing, promoting, and providing more effective professional support from a structural level.

2.1   Structure

This section introduces previous studies and arguments on the issue of the mental health of immigrants.   Both mental health and immigration, respectively, entail boundless challenging aspects that have required and received much attention from society including academia.   Combined, the 'mental health' issues of 'immigrants' consist of no less complicated dimensions of phenomena that are worthy of societal recognition and consideration, especially against the backdrop of globalisation.

The literature review covers previous studies on the issues of Korean ethnicity; their immigration and subsequent wellbeing.   The first part discusses commonly noted and considered issues generated by immigration.   One of the difficulties an immigration experience may involve—social isolation, feelings of alienation and loneliness — are discussed in greater detail.   The second part discusses how previously discussed difficulties may have a negative effect on the overall mental well-being of immigrants.

Illness behaviours—how people perceive and respond to illness—may vary in various cultures as the definition and treatment of an illness may differ from culture to culture.   Such culture-bound illness perception will affect one's help-seeking pattern and cure-strategy.   The third part of the literature review introduces some of the characteristics and features commonly known either as 'Korean' or 'Asian.'   In the next part, the fourth, Korean people's general perspectives and attitudes towards mental ill-ness (as apposed to well-ness) are discussed.   This part includes a discussion on how such culture-bound perspectives on mental ill-ness may affect a

person's illness-behaviour, including how one conceives, expresses, and recognises psychologically challenging states of mind. How a Korean person—both as a person with difficulties and as a close observer—may react to such situations is also examined in this part. The fifth part examines how cultural aspects known either as Korean or Asian may have an impact on a person's coping strategies including help-seeking and the choice of treatment option. The last part discusses the commonly known 'under-utilisation' of professional mental health services and the possible impact of culture on this phenomenon.

2.2   *Korean-New Zealander Profile*

The fastest growing ethnic community in New Zealand comprises Asians (Ho et al., 2002). In the decade between 1991 and 2001, the number of people identifying themselves as Asians or belonging to Asian cultures more than doubled to almost 240,000, that is, 6.6% of the total population (Statistics New Zealand (SNZ hereafter), 2002). The rather broad and umbrella category of 'Asians' is composed of different ethnic groups with distinctive cultural and linguistic heritages. Among individual Asian ethnic groups, Koreans comprised the third largest group (8%) following Chinese and Indian, increasing by more than 20 times from 930 in 1991 to 19,023 in 2001. Koreans were also the fastest growing Asian community in percentage terms (SNZ, 2002).

The 2001 census reported that the recent (people who had been residents in New Zealand for less than 10 years) immigration comprised 92% of the total Korean population (Korean-New Zealander, hereafter). Only five percent of Korean-New Zealanders were born in New Zealand and ninety-nine percent of them were reported as born in the Republic of Korea (commonly known as South Korea) (SNZ, 2002).

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The majority of the recent Korean immigrants came to New Zealand following a fundamental change in New Zealand immigration policy in 1986, which aimed at attracting immigrants with professional skills and capital for investment, irrespective of race and country of origin (Ho et al., 2002). Perhaps not surprisingly, then, Korean-New Zealanders were one of two ethnic groups with the lowest proportion of English speakers (SNZ, 2002).

69% of Korean-New Zealanders were living in the Auckland Main Urban Area (MUA) in 2001, followed by Christchurch MUA (15%) (SNZ, 2002). Only 29% of the total population of New Zealanders lived in Auckland (Ho et al., 2002).

A relatively lower rate of the Asian groups were participating in the New Zealand labour force. The Asian Public Health Project Team (APHPT, hereafter) (2003) found that while one-third of Asian people have a tertiary education, this group of people was over-represented in unemployment rates (worse then the average rates of New Zealand), and subsequently, earning a significantly lower income. The unemployment rate was even higher among Korean-New Zealanders, consistent with the lowest median annual income of this group ($5,300), reflecting its relatively low level of labour force participation (SNZ, 2002). However, in contrast to this, 93% of Korean-New Zealanders were found to have a formal education. For example, the survey report conducted by the Waitemata District Health Board (WDHB hereafter) (2002) found that among Korean-New Zealanders aged over 25 years, almost 92% had tertiary education qualification.

While the Asian group was found, overall, to be relatively healthy due to the youthful age profile, the APHPT (2003) identified five specific areas of concern. The risk of degenerative mental health was pointed out as one of the areas of concern

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with some of the contributing factors recognised as: language barriers; social isolation; under-employment, and stigmatisation (APHPT, 2003).

2.3   Legal Alien: The Challenging Nature of the Immigration Process

Immigration experiences involve far more than a physical transfer from a country of one's origin to another. Studies reported that immigration experiences alone be a tremendous stress factor which could lead to mental health problems such as anger, anxiety, depression, family conflicts, and alcohol abuse (Berry, 1992; Brown, Abe-Kim, & Barrio, 2003; Constantine, Okazaki, & Utsey, 2004; Hurh WM. & Kim KC, 1990a; Hurh WM. & Kim KC, 1990c; Kim YS, 2002; Lee SSW, 2004; Lee, Crittenden & Yu, 1996; Noh & Avison, 1996; Rosenthal & Schreiner, 2000; Selvaraj, 2001; Vandervoort, Divers, & Madrid, 1999)[1].

Difficulties in adjustment and settling into a foreign environment might generate psychological distress (Bae SW & Brekke, 2002; Brown et al., 2003; Selvaraj, 2001; Yeh & Inose, 2002). Although individual differences might exist (Kim YS, 2002), immigrants were often under pressure bearing challenges such as linguistic barriers and cultural shock (Brown et al., 2003; Cho YB, 2003; Choi H, Stafford, Meininger, Roberts, & Smith, 2002; Hurh WM & Kim KC, 1990a; Kemp & Rasbridge, 2004; Selvaraj, 2001; Yeh & Inose, 2002). Marginalised or socially disadvantaged groups were not the only victims of immigration stresses. Studies found that even well-educated and socially-established immigrants experienced significant level of continuous distress (summed by Kemp & Rasbridge, 2004). Colhound and Maxwell's (1987) study on a correlation between socioeconomic and demographic

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[1] According to Kim, Y.S. (2002), individuals who perceived situations as controllable were mentally healthier than those who felt helpless and overwhelmed by stressors.

indicators and wellbeing (both physical and psychological) reported little, if any, link between the two variables. The authors claimed that physical and psychological heath (or ill-health) might be more dependant on social competence involving perceived self-esteem and meaningful social relationships (Colhound & Maxwell, 1987). For example, social anxiety and loneliness could generate illness from a person with materialistic "bliss," suggested the study. On the contrary, social support could act as a buffering factor in experiencing "misery" and stressful life events, preventing the development of physical or psychological illness.

As Lee SSW (2002) claimed, lack of linguistic competency might hinder Korean-New Zealanders' chance to become acquainted with and absorbed into the adopted country. Linguistic proficiency or competence entailed more than the ability to be engaged in technical and daily conversations with other people. The APHPR (2003) claimed that limited linguistic ability could even be a risk factor for the general well-being of non-English speakers. Linguistic barrier could often downgrade social-economic position, diminishing opportunity for employment and income, in a new society. This could lead to low self-esteem, perceived loss of face, negative self-perception, and subsequently, withdrawal from society (Chang CY & Meyers, 1997; Kemp & Rasbridge, 2004). While language was a stress factor, it could even be a prohibiting factor in accessing support upon experiencing psychologically distressing moments during immigration (Constantine et al., 2004; Kemp & Rasbridge, 2004; Kim YS, 2002; Yeh & Inose, 2002).

Fitting into a foreign society, establishing financial stability, and family conflicts were a few issues immigrants needed to confront as 'the others' (Chang CY & Meyers, 1997; Ho, Rasheed, & Rasheed, 2004; Hurh HM & Kim KC, 1990a; Kemp & Rasbridge, 2004; Kim YS, 2002; Selvaraj, 2001). Perceived discrimination and

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exclusion from a society could also be stress factors and possibly, generate feelings of depression (Brown et al., 2003; Chang CY & Meyers, 1997; Kemp & Rasbridge, 2004; Noh & Kaspar, 2003). Loss of or lack of a social support system and social isolation could aggravate the adaptation stress of immigrants who had limited resources to resolve such issues (Choi et al., 2002; Ho, Rasheed, & Rasheed, 2004; Kemp & Rasbridge, 2004; Kim YS, 2002).

Social resources and support could be a critical factor empowering immigrants to cope with perceived discrimination (Hurh WM & Kim KC, 1990a; Noh & Kaspar, 2003)[2]. Social support could enable a person to perceive such matter in a problem-focused way, to confront the issue in an active way, and thereby to release stress level and prevent possible depressive symptoms caused by perceived discrimination (Noh & Kaspar, 2003). Noh & Kaspar (2003) also noted that social support would even diminish and moderate distress levels caused by such discrimination.

Social networks were found to be a critical and effective social resource that functioned as a protective factor for Asian immigrants upon experiencing distress (Cho YB, 2003; Lee, Crittenden & Yu, 1996; Noh & Avison, 1996; Noh & Kaspar, 2003; Noh, Speechley, Kaspar & Wu, 1992a; Taylor, Sherman, Kim HS, Jarcho, Takagi, & Dunagan, 2004; summed by Yeh & Inose, 2002). Social networks helped people define the nature of distress and find appropriate coping strategies (Brown et al., 2003). A social network was also a significant factor in the recovery and treatment stages of experiencing psychological distress. Social support provided

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[2] In Korean communities, churches usually have more functions than delivering religious services. As Hurh, WM & Kim KC (1990b) explained, churches were a part of many immigrants' life partly due to the socio-demographic background of many immigrants. In addition, churches provided services and support relating to the immigrants' settling in process such as interpretation, translation, community activities, place of social gathering and information sharing.

people with psychological stability and security such as the perception of being loved, cared for, valued, and included (McMinn MR, Roh SH, McMinn, LG, Dominguez, Rhee ER, Maurina, Kim E, Rutter, & Chae PK, 2001; Taylor et al., 2004). Lee, Crittenden & Yu (1996) found that elderly Korean immigrants with stronger social resources resulted in fewer cases of depression. On the other hand, the perceived lack of social support could result in more severe cases of depressive symptoms in immigrants (Mui, 2001; Taylor et al., 2004),

The concept of 'social support' entailed a variety of definitions and components (Sommer, 1990). It could mean social relationships (friends, partners, or community involvement), the nature of social network, quantity and quality of social interactions, or perceived lack/sufficiency of social interactions. The nature of support also varied: emotional (empathy, listening, for example); problem-solving (information, advice, for example); practical and material; and social integration (involvement in supportive social system) (Sommer, 1990). While different situations would call for different types of support, Sommer (1990) pointed out the role of the individual's social competence in developing and utilising social support. A person would need to acknowledge the need for getting support and to be able to ask for support. Such a process would require a range of individual social competences such as: social skills; securing intimacy; absence of social anxiety; the willingness to express the need for help; and receiving the necessary help (Sommer, 1990).

Rokach (2000) described loneliness as a subjective phenomenon. Different people experienced varying degree of loneliness depending on personal and situational variables (Rokach, 2000). Should a person wish to belong to a certain societal group and yet fail to do so, the person would be unsatisfied with the status quo of social relations and might experience loneliness and alienation. According to Sommer

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(1990), life satisfaction was not independent of perceived level of social support and resulting positive relationship experiences. Contrarily, dissatisfaction with life, presumably caused by the gap between the expected/desired state and the reality, was pointed out as one of the prominent causal factors of loneliness (Neto & Barros, 2003).

Kim OS & Baik SH's (2002) study of elderly Korean women's loneliness found a negative correlation between loneliness and social connectedness; the perceived lack of a social network and support increased the participants' feeling of loneliness. In New Zealand, the annual Social Report (the Ministry of Social Development (MSD hereafter, 2005) included 'loneliness' as one of indicators of social wellbeing. The Social Report's emphasis on having constructive relations with others—from the family to the workplace—showed a correlation with Kim OS & Baik SH (2002)'s findings: having relationships with other people increased the level of feeling 'social connectedness'. The Social Report (MSD, 2005) identified the social connectedness—including having available social support and relationships—as one of the essential factors that contributed towards the level of personal health and wellbeing, and subsequently, the wellbeing of an entire society. Relationships would not only provide actual support when a person was in need. Having relationships also provided a person a secured feeling of having reliable support system should he/she experience difficulties in life (MSD, 2005). Having relationships did not only put a person at the receiving end. To have relationships and by having relationships, a person was entitled to roles in society to function and be included. Having relationships with other people implied inclusion and belongness to a society (MSD, 2005). Feeling lonely and being disconnected from the outer world may not be a transitional state of emotion that could simply tolerated and ignored. Being deprived of such social connectedness might affect soundness and healthiness of one's mental

health, possibly precipitating mental illnesses such as extreme stress, anxiety, and depression (MSD, 2005)[3].

Although loneliness was found to be a subjective experience of individuals, the degree of loneliness and social connectedness was not a state that could be manipulated solely by an individual's determination to feel 'better'. A person would need the 'skills' and 'opportunities' for regular contact and interaction with other people in order to build social connectedness (MSD, 2005). The immigration experience usually includes leaving a social network behind in the native country. The MSD's survey result regarding the degree of regular contact a person has with families/friends could have been expected. The survey revealed new migrants had a lower frequency of regular contact with families/friends than those born locally. Naturally, perhaps, the Asian group of people reported the highest level of self-assessed loneliness in the survey (MSD, 2005).

A study found that depressive symptoms were more prevalent in Korean immigrants (Kuo, cited in Solberg, Ritsma, Davis, Tata & Jolly, 1994). Lee SSW (2002) explains that the traditional Korean society was based on and operated according to a community-oriented life style—also known as 'collectivism.'[4] While individualism brought about by domestic and international changes might have compromised collectivism, collectivistic behavioural patterns remain as the exclusive and 'in-

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[3] While the availability of adequate social support could enhance personal well-being, Sommer (1990) suggested the possibility of an inverse impact on social relations—'social strain'. Social strain could decrease a person's psychological well-being through criticism, rejection, overprotection, and abuse. In addition, the negative influence of a social network could also include the reinforcement of misconduct or improper behaviour (Sommer, 1990).

[4] More discussion on collectivism is provided later in the chapter.

group' nature of many Korean people. Acculturation in terms of values and behaviour would take place at a different rates; usually acculturation in behaviour takes place at the earlier stage of immigration compared with acculturation in values (summed by Kim BS et al., 2001). Lee SSW (2002) suggests that lingering collectivism in the case of Korean immigrants could add to the challenge of becoming acculturated and involved in a new society.

In addition to collectivism, perfectionism was also pointed out as a feature that could put the mental well-being of Asians at risk. For example, in academic settings, Asian students were often described as more anxious, stressed, emotionally withdrawn, verbally inhibited, and socially introverted and withdrawn compared to their Caucasian counterparts (Gim RH, Atkinson, & Whiteley, 1990; Okazaki, 1997; Sue & Sue, 1987). It was suggested that a perfectionist tendency among Asians and especially Koreans, and subsequently a high level of emotional distress could cost them mental health problems such as depression or social anxiety (Okazaki, 1997; Vandervoort et al., 1999). Vandervoort et al. (1999) argued that perfectionism generated unnecessary worries and nervousness in people who feared failure or disapproval.

A combination of the 'introverted' personality features and perfectionism might cause more social anxiety among Korean immigrants. A less-than-fluent linguistic command in the dominant language of the host society could result in seemingly helpless isolation from others, prohibiting the chance to form a new social network as Korean immigrants settle down in a new society.

2.4   *Behind the Scenes of Model Minority: Impacts of Immigration*
          Stress on Well-being

Korean immigrants were often referred to as a 'model minority'. This particular

ethnic group was observed as being well-adjusted in academic and business sectors

in the immigration process. Low-rate in mental health utilisation also supported this

'model-minority' label, which presupposed Koreans were generally healthy and did

not have many problems in a settlement process (Lee & Darnell, 2002; Solberg et al.,

1994; Sue & Sue, 1987). However, as discussed in the previous section, the

immigration process can be no less challenging for Koreans than for people from

other ethnic and cultural backgrounds. In the US, Korean immigrants were reported

as suffering from a higher prevalence of anti-social personality disorders including

alcohol addiction, compared to other ethnic groups (Muczak, Wall, Cook, Shea &

Carr, 2004). Selvaraj (2001) came from a different perspective and identified factors

other than 'being a model minority' to understand the low representation of Asians in

substance abuse services: utilisation of traditional medicine; reluctance and

scepticism towards counselling treatment; family involvement; linguistic and cultural

barriers in accessing relevant services; and reliance on religion (the issue of the under

utilisation of professional health care is discussed in the latter part of the literature

review).

It was suggested that a socio-cultural and psychological context—in this case,

immigration—could induce, aggravate or ameliorate psychological distresses

(Kagawa-Singer & Chung, 2002; Pang, 1990). Among a broad spectrum of

immigration difficulties, this section reviews how reduced/lack of social relations

could have a negative impact on the mental health of the new settlers.

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2.4.1 Loneliness

Loneliness is an emotional experience that does not discriminate amongst people on the basis of their individual backgrounds, time, culture, place, religion, and other measurable or nominal factors (Rokach, 2004). It is also one of the most 'general' and commonly experienced emotions regardless of historical and geographic settings (Rokach & Bacanli, 2001; Rokach, 2000). The Social Report (MSD, 2005) identifies isolation and loneliness as a detrimental factor in the health and wellbeing of people—more specifically, it can even cause mental illness such as stress, anxiety and depression. As the historical motto of the Olympics games proclaims 'Anima Sana in Corpore Sano' (sound mind, sound body), emotional state—in this case, loneliness—could undermine not only the psychological well-being, but also the physical health of a person.

Medical research has found a connection between the mind and the body; and how a seemingly subjective feeling of loneliness could impact on the psychological and physical conditions of human beings. According to Ornish (2005), people who have experienced prolonged loneliness could often engage in self-destructive behaviours— such substance abuse, behavioural disorders, poor eating and exercising habit, for example—, which could consequently undermine or destroy both the physical and psychological dimensions of an individual. Other studies reported that having inadequate friendships and consequently suffering loneliness could result in poor mental health such as depression in people from different ages and ethnic groups (Adams, Sanders, & Auth, 2004; Lauder, Sharkey, & Mummery, 2004; Le Roux & Connors, 2001; Nangle, Erdley, Newman, Mason, & Carpenter, 2003; Wright, 2003).

Studies also documented social isolation and loneliness as factors triggering cardiovascular disease and even premature death, while the opposite feeling – that of being cared for and loved could be a preventive or treatment factor for the same disease (Ornish, 2005). Research in the UK found that social isolation and related stress could increase levels of cholesterol and blood pressure, which could generate heart disease (Ornish, 2005). Radha & Prathima (2004) conceived loneliness as an "ailment" that could even force people to resort to an extreme measure. People residing in an 'alien'—non-native—place, separated from a native social network, would often be under extreme stress which could even result in suicide (Radha & Prathima, 2004).

Loneliness is claimed to be a 'social' problem that extends beyond an individual's melancholic feelings (Rokach & Hasan, 2001). In addition to harming the mental and physical health of individual members of society (Lauder, Sharkey & Mummery, 2004), and thereby decreasing the general level of well-being in a society. Lauder et al. (2004) claimed that loneliness should be treated as an important public health issue and therefore, be detected, prevented, and ameliorated at policy level.

Contrary to the 'model minority' labelling, studies generally agree that Korean immigrants are no more 'healthy' than people belonging to other ethnic groups. In fact, studies argue that Korean immigrants suffered more psychological difficulties as a result of immigration experiences. The significance of the distress level resulting from immigration—especially depressive symptoms—among Korean-Americans (KA) was found to be no less than, or even higher than that of their Caucasian or other ethnic counterparts (Akutsu, Snowden, & Organista, 1996; Atkinson & Gim RH, 1989; summed by Choi H et al., 2002; Crittenden, Fugita, Bae, Corazon & Chien, 1992; Hurh WM & Kim KC, 1990a; Jang Y, Small & Haley,

2001; Kim BS, Ng, & Ahn, 2005; Kim YS., 2002; Lee SSW, 2004; Lee & Darnell, 2002; Lee, Crittenden & Yu, 1996; Mui, Kang, Chen & Domanski, 2003; Mui, 2001; Okazaki, 1997; Rosenthal & Schreiner, 2000; Solberg et al., 1994; Sue & Sue, 1987; Tracey, Leong & Glidden, 1986; Yamashiro & Matsuoka, 1997; Yeh & Inose, 2002; Yoo & Skovhholt, 2001; Zane, Hatanaka, Park & Akutsu, 1994). In fact, Kim SC, Lee SU, Chu KH, & Cho KJ (1989) found that most frequent mental problems among Korean-Americans (KA hereafter) were depressive symptoms, followed by schizophrenic disorders and parent-child conflicts. The study also found that, among KAs, foreign-born KAs experienced more psychological difficulties compared with their US-born counterparts (Choi et al., 2002). The somatisation tendency was also higher among the foreign-born KAs (Choi et al., 2002).

2.4.2   Model Minority and Under Utilisation of Services

However, the high prevalence of psychological difficulties did not become apparent when relevant service utilisation rate was documented. On the contrary, studies reported under-representation of Korean immigrants in mental health services (Akutsu, Tsuru, & Chu, 2004; Akutsu, Snowden, & Organista, 1996; Atkinson & Gim RH., 1989; Brown et al., 2003; Chandras, Eddy, & Spaulding, 2000; Chang SY & Myers, 1997; Constantine et al., 2004; Heah, 1998; Kim MY, 1994; Kim BS, Ng, & Ahn, 2005; Lee & Darnell, 2002; Shin JK., 2002; Sue & Sue, 1987; Tracey, Leong, & Glidden, 1986; Watari & Gatz, 2004; Yamashiro & Matsuoka, 1997; Yoo YG, 2002; summed by Zane et al., 1994). Although it might be tempting to interpret under utilisation as a sign of the 'well-adjusted' and 'mentally healthy' status of Korean immigrants, studies claimed otherwise as discussed above (Sue, 1994; Sue & Sue, 1987). Stereotyping of Koreans as a 'model' minority of a society could veil the socio-economic pressures and overall adjustment distress this particular ethnic

group was experiencing (Solberg et al., 1994; Sue, 1994). In addiction, emotional and psychological difficulties experienced during the immigration process were often neglected as immigrants would have more urgent issues that required immediate attention and action such as securing the material aspects of life (Shin SK & Lukens, 2002). If so, stressful immigration experiences could be a trigger of mental illnesses, while at the same time, being an obstacle in accessing proper health services.

As discussed, studies on Korean immigrants' mental health and relevant service utilisation revealed the high prevalence of psychological difficulties on the one hand and the low utilisation of professional services on the other (for example, Kim YS, 2002; Lee SSW, 2004; Snowden & Cheung, 1990; Watari & Gatz, 2004; Yoo YG, 2002; Zane et al., 1994). It might be interesting to note, however, that contrary to the popular tendency of under utilisation of mental health services in the Asian population (including Koreans), some studies found over utilisation of campus counselling facilities among Asian college students in the US (Atkinson, Lowe, & Matthews, 1995; Gim RH, Atkinson, & Whiteley, 1990; Tracey, Leong, & Glidden, 1986; Solberg et al., 1994). The studies also found different 'causes' for seeking counselling help. Compared with other ethnic groups, Asian students' major concerns were academic and career achievement (Gim RH, Atkinson, & Whitely, 1990). Gim RH, Atkinson, & Whiteley (1990) reported that Korean people were more concerned with the academic and financial aspects of life than their other Asian counterparts. Some interpreted the over utilisation of services as being due to the less stigmatising nature of academic/career counselling services. Tracey, Leong, & Glidden (1986) suggest that Asian students might choose to mention more acceptable and 'practical' issues—such as education and career—as an 'entrée' to discuss emotional problems. Others suggest that compared to other ethnic groups, Asian Americans were more prone to attribute their stress to concerns regarding academic

achievement and career success rather than to emotional and personal concerns (Gim RH, Atkinson, & Whiteley, 1990; Tracey, Leong, & Glidden, 1986; Yamashiro & Matsuoka, 1997). Strong emphasis on education in the Korean culture and 'great' expectations from families regarding success—especially in the light of their status as immigrants—might put extra pressure on young Korean immigrants (Tracey, Leong, & Glidden, 1986).

2.4.3   Acculturation and mental health

Not every person under the same stress would experience deterioration of mental wellness (Salant & Lauderdale, 2003). Likewise, not every immigrant would develop mental health issues. However, some studies report a significant correlation between acculturation level and mental health level. The process of acculturation itself can be very stressful (Berry, Kim UC, Minde, & Mok, 1987; Constantine et al., 2004; Tsai & Chentsova Dutton, 2002). Many reported that immigrants would experience feelings of isolation and alienation and identity confusion, which could be detrimental to general health including mental, physical, and even social aspects (Berry, 1992; Berry et al., 1987; Constantine et al., 2004; Salant & Lauderdale, 2003). While the challenging nature of the immigration process could generate an enormous amount of stress, the outcomes of immigration could vary from very positive to very negative (Berry, 1992; Constantine et al., 2004; Salant & Lauderdale, 2003). It was generally agreed that the more and successfully acculturated immigrants would experience fewer psychological problems (Oh YS, Koeske & Sales, 2002; Yamashiro & Matsuoka, 2001)[5]. Gim, RH, Atkinson, Whiteley (1990) explained

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[5] In addition to acculturation level, a stable and strong ethnic identity was also found to be a protective factor against stress and depression (Oh et al., 2002). They would also be more active in

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that as people became more acculturated, value conflicts between two cultures tended to reduce, subsequently enhancing mental well-being and emotional stability. Studies found other significant associations between acculturation level and other issues relating to the mental health of immigrants; preference for counsellor ethnicity; attitudes toward professional psychological help; preference for counselling types; and willingness to seek counselling help (summarised by Kim BSK, Atkinson, & Yang, 1999).

Another positive correlation existed between acculturation level and help-seeking behaviour (Atkinson & Gim, 1989; Atkinson, Lowe, & Matthews, 1995; Chang CS & Meyers, 1997; Gim RH, Atkinson, & Whiteley, 1990; Kim BS., Ng, & Ahn, 2005; Leong, 1986; Kim BSK, Atkinson, & Yang, 1999; Oh, Koeske & Sales, 2002; Okazaki, 1997; Yamashiro & Matsuoka, 2001; Zhang & Dixson, 2003). It was suggested that the more acculturated and well-adjusted Korean immigrants might be more proactive in the recognition of problems and accessing proper health services. Acculturation level was also associated with other aspects of experiencing psychological distress: preference for counsellor ethnicity; attitudes toward professional psychological help; preference for counselling types; willingness to seek counselling help; and positive compliance with a psychiatric treatment process (Atkinson & Gim, 1989; summarised by Kim BSK, Atkinson, & Yang, 1999; Zhang & Dixson, 2003).

However, Lee DY's (2002) study reported otherwise. He studied how acculturation influenced psychological help-seeking and found no correlation between the two

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seeking professional help upon experiencing emotional distress (Chang SY & Myers, 1997; Yamashiro & Matsuoka, 2001).

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variables. Okazaki's (1999) study also found no relation between acculturation level and stigma against mental health issues. Gim RH, Atkinson, & Whiteley (1990) even suggested that people who were less acculturated might acknowledge more concerns in their life and therefore, be more willing to seek professional help than more acculturated people.

2.5   Culture Korean: Culture-bound Characteristics of Korean Immigrants

2.5.1   Collectivism

Asia refers to a certain geographic region and Asian refers to something of the continent of Asia. There are some characteristics commonly known as 'Asian'; the features that reflect commonalities among different countries and cultures in Asia (Chang SY & Myers, 1997; Kim BS, Yang PH, Atkinson, Wolfe & Hong S, 2001). Collectivism would be one of the commonly known features of Asia (Bae SW. & Brekke, 2002; Chandras et al., 2000). Collectivism was viewed as one of the results of well-known Asian philosophies such as Confucianism, Buddhism, and Taoism (Kim BS et al., 2001). Emphasis on the family and a strong family structure, filial piety, (especially emotional) self-control and restraint, norms of hard work, education, shame as a control mechanism, less emphasis on individualism and more emphasis on interdependence and interpersonal relationship, prioritising group harmony, and conformity to norms are believed to have flowed from the above mentioned philosophies (Bae SH, Joo & Orlinsky, 2003; Chandras et al., 2000; Chang SY & Myers, 1997; Donnelly, 2001; Ho, Rasheed, & Rasheed, 2004; Kim BS., Ng, & Ahn, 2005; Kim BS et al., 2001; Okazaki, 1997; Purnell & Kim, 2003; Watari & Gatz, 2004; Yoo, YG, 2002).

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Studies investigated the dichotomised concepts of collectivism and individualism. The two psychological concepts often represented the fundamental and distinctive behavioural features of Asian and Western culture, respectively (Oyserman, Coon, & Kemmelmeier, 2002; Rhee, Uleman, & Lee, 1996; Triandis & Gelfand, 1998). A good starting point for a dichotomous view of collectivism and individualism would be 'selfhood'. It has often been explained that in collectivism, the self is defined by relationships with other people, and therefore as an interdependent being. Opposed to this is the belief that 'self' means being an 'independent' being in an individualistic society (Okazaki, 2002). Collectivism often refers to exclusiveness to out-group members and equality norms and interdependence to in-group members. Individualism, on the contrary, is attributed to the independent and autonomous being of an individual regardless of membership to a certain group. Equity, rather than equality, is emphasised within in-group members in individualism. Communication style is another noticeable feature distinguishing collectivism from individualism. While the former appreciates indirect and face-saving inter-relation and harmonisation, the latter is renowned for direct intercommunication and acceptance of confrontation/conflicts within a group (Kashima, Kim, Gelfand, Yamaguchi, Choi, & Yuki, 1995; Oyserman, Coon, & Kemmelmeier, 2002; Rhee, Uleman, & Lee, 1996; Triandis & Gelfand, 1998). The behaviour patterns and value systems of people with an Asian background are often referred to and explained in terms of a collectivistic framework. Collectivism is a structure upon which a comparison is made between Asian and Western people as it is commonly assumed that Asians are collectivists while Westerners are individualists (Miller, 2002; Oyserman, Coon, & Kemmelmeier, 2002; Rhee, Uleman, & Lee, 1996).

In an 'individualistic' society, psychological wellbeing is determined primarily by personal emotions. On the contrary, within a society where collectivism is a dominant value, social norms and external standards influence a person's emotional health (Okazaki, 2002). Moreover, an individual's behaviour accounts for the groups that individuals belonged to. For example in a collectivistic culture, studying and working hard, and resulting success, are seen as the achievement not only of one person but also of an entire family. Such an emphasis on diligence and familial responsibility could sometimes motivate and at other times burden individuals in striving for the "best" (Lee M, 2004). In the same light, an individual failure to meet the social norms and expectations could be seen as a slur on the family name—or loss of 'face' (Kim I, 1981; Lee M, 2004; Purnell & Kim, 2003). The wrong or shameful deed of a member of a group could ruin the reputation of the entire group's members (Yamashiro & Matsuoka, 2001). Therefore, members of a collectivistic society learned to control their behaviour and thoughts properly in order to avoid being criticised by outsiders and causing the entire group to lose face.

Stoicism is also a notable feature of Asian culture. The aforementioned oriental philosophies considered suffering as a natural part of life and, therefore, an experience that should be endured (Donnelly, 2001). In terms of the philosophies, every event in life—especially painful experiences—have their meaning and people need to find the intrinsic meaning and learn a lesson in the course of perseverance. A suppressive defensive mechanism is a feature of the Asian culture and the 'suppression' of feelings is seen as a sign of personal maturity (Tseng, 2004)[6].

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[6] Korea also has proverbs that emphasise suppression as a virtue. For example, "Three suppressions can prevent a death (of other party)" is the saying teaching people the value of self-control and maintaining calmness even under an extreme circumstance.

2.5.2 Revisioning Collectivism

Triandis & Gelfand (1998) stress that there should be no superiority/inferiority judgement attached to an analysis of cultures based on collectivism/individualism. Various cultures have developed their own value/behavioural system that reflect their historical and social contexts. Therefore, an analysis of cultural typology should include an examination and understanding of socio-cultural construct. While collectivism is popularly accepted as a value that represents Asian culture, a revision and re-examination of the collectivistic features of the 'Asian' has been conducted by some scholars (Wong & Tsang, 2004). It is generally believed that Confucianism taught people to harmonise and be submissive to the collective value. However, this philosophy along with another 'Asian' philosophy of Taoism in fact valued 'individuality'. Confucianism and Taoism both value courage and the integrity to go against the main flow and to oppose authority when one believes in one's choice and value (Wong & Tsang, 2004).

Another erroneous concept of collectivism is that it conveys the subordination of individuals to their groups and calls for the identification of group-goal vs. self-goal (Kashima et al., 1995; Miller, 2002). Miller (2002) argues that this is a typical example of viewing other cultures out of context. Miller (2002) explains that the collectivistic tendency might be perceived as 'subordination'—and therefore, as a negative by observers from other cultures. However, for many Asian people, harmonisation within the group could bring personal achievement and satisfaction. In addition, the concept of self or self-construal could vary among different cultures (Miller, 2002). Kashima et al., (1995) also suggests that a clear distinction between individual-collectivistic characters could often be vague and unclear. The definition and acquisition of an 'in-group' position —a significant measurement that

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distinguishes collectivism and individualism—could also differ among cultures. In general, the 'Asian' in-group would refer to the 'born-with' relations, such as family and relatives. On the contrary, the 'Western' in-group would include the socially-developed relations, such as friends who have similar values and beliefs to the person developing the relationship (Rhee, Uleman, & Lee, 1996). At the same time, it should also be noted that not every single person with an Asian background would appreciate such a construal of collectivism. As Quinn & Holland (cited in Kashima et al., 1995) suggest, the theoretically rigid characterisation of 'other' cultures might reflect a traditional cultural norm of the culture being observed, rather than the authentic real life views of people currently living within that culture.

Others examined the perceived 'lump-sum' collectivistic essence of the Asian people and looked into whether the single notion of collectivism could homogeneously be applied to different cultures and ethnicities belonging to 'Asia' (Triandis & Gelfand, 1998). Heterogeneity among different 'Asian' countries could no less be noticeable than the differences between 'Western' and 'Asian' cultures (Bae SW & Kung WW, 2000; Brown et al., 2003; Kim BS et al., 2001; Kim LS & Chun CA, 1993; Kim WS, 2003; Selvaraj, 2001; Stuart, 2004; Sue, 1987; Tracey, Leong, & Glidden, 1986; Yamashiro & Matsuoka, 1997; Zane et al., 1994). While the influence of the renowned traditional Asian philosophies might be undeniable in seeking to understand Korean culture—one of the two oldest continuous civilisations in the world, second only to Chinese (Purnell & Kim, 2003)—, the influence of such philosophies on contemporary Korean society might require further discussion. As in other cultures and societies, 'Asian' cultures went through different processes of transition and evolution (Wong & Tsang, 2004; Sue & Sue, 1987). For example, as Kim BSK et al. (2001) explained, compared to other neighbouring Asian countries such as China and Japan, Korea has been largely influenced by Christianity, and

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therefore, shows less adherence to the 'Asian' value of collectivism. The influence of Christianity should also be taken into account because churches have played a crucial role in immigrant communities, providing emotional and practical support (Choi G, 2003; Purnell & Kim, 2003)[7]. As Triandis (cited in Miller, 2002) notes, different varieties of collectivism/individualism should be addressed and acknowledged in order to properly understand various cultures.

The Oyserman, Coon, & Kemmelmeier's (2002) study found the collectivistic nature present to a different degree among Asian countries. The study found that Korea and Japan showed far less of collectivistic tendency than China. In fact, the study found little difference between Korea and the US in their collectivistic/individualistic tendencies. Another study by Kashima et al. (1995) found differences between the Japanese and Korean cultures. Relatedness with others at an empathetic level was found to be a crucial factor in building and sustaining inter-relationships among Korean people. The study noted some Korean words, an exact equivalent of which could not be found in the English vocabulary. This represents the Korean emphasis on mutual-understanding and shared-sentiments[8]. Different historical events and

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[7] Choi's (2003) description of church functions in Korean immigrant communities in the US showed a variety of services provided by the particular religion. Churches would provide practical support for immigrants ranging from settling in services, translation services, elderly care, and networks to connect Korean entrepreneurs with one another. Churches also provide emotional support as they are venues where regular social gatherings can take place, and a social network and culture can be maintained.

[8] The Korean words 'jeong' (similar to, but not the same as, 'affection'/'attachment') and 'woori' (meaning we, our, ours, us) were examined in their study (Kashima et al., 1995). 'Jeong' is an emotion created by having shared for a reasonably long time together whether as friends, partners, colleagues, or even neighbours. For example, it is a 'linguistic norm' to say 'woori Umma', which literally means 'our mother' and which should, strictly speaking, be translated as 'my mother'. It

modernisation processes partly explain the differences between two neighbouring countries (Kashima et al., 1995).

In addition to inter-cultural differences among different Asian countries, the process of the internalisation of global and social changes could vary among individual Koreans. Within the context of rapid change in a fast-paced society, people might experience internal and external conflicts between collectivism and individualism (Bae SH, Joo & Orlinsky, 2003). Therefore, individuals could have different behavioural patterns and value systems even when they belong to the same culture (Bae SW & Kung WW, 2000; Brown et al., 2003; Wong & Tsang, 2004; Yamashiro & Matsuoka, 1997). Individual achievement, individual well-being, and pursuing individual satisfaction in life could sometime clash with 'collectivistic' values. In other words, many Korean people would prioritise their success and happiness over maintaining and sacrificing for group harmony. Describing and understanding the Korean people and culture based on traditional features of the Korean—or Asian— society might result in stereotyping and misunderstanding of a heterogeneous society (Stuart, 2004; Wong & Tsang, 2004).

Wong and Tsang (2004) even argue that the concept of 'harmony' was often used to suppress women in the traditional Korean society and that this concept is still sometimes imposed upon women. In the traditional setting, women's achievements were recognised when sacrifice was made for domestic reasons, while an independent and enterprising nature in men was much encouraged and praised (Wong & Tsang, 2004). As Purnell & Kim (2003) explain, 'modern' Korean people—especially women—might not adhere to traditional values, and rather be

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would sound awkward to say and hear 'my' mother, instead of 'woori' mother, in the Korean language even when the speaker is the only child.

strongly affected by liberal values that have spread from the Western culture. The higher divorce rate might partly reflect rapidly changing social values and consequent conflicts between traditional norms and the pursuit of individual goals (Bae SH, Joo, & Orlinsky, 2003).

The dichotomised or bipolar analysis of collectivism/individualism in socio-cultural psychology had a critical limit in understanding the 'others'—in this context, Asian cultures—by the outsider (or Westerners)'s perspective. As Miller (2002) argues, the dichotomy is based on Western paradigms. In other words, the dichotomy emerges when a comparison is made between Asian cultures and the framework constructed based on Western mainstream construct. Viewing another culture through an existing lens is likely to lead to the neglect of the historical and social context of that particular culture and will also limit the spectrum to capture the genuine essence of that target culture (Miller, 2002). A dichotomous observation and understanding of the 'others' would risk negligence of complex and dynamic social structure and different experiences of members of that society (Miller, 2002; Rhee, Uleman, & Lee, 1996). In this sense, Rhee, Uleman, & Lee (1996)'s study provided a rather interesting finding on the collectivistic/individualistic nature of the Korean people. The study found that while showing collectivistic attitudes towards in-group members, Korean people had more 'individualistic' attitudes towards out-group members. The same study also found that a similar degree of 'relationality' to close kin is found among people from both the Korean and Northern American cultures. Triandis & Gelfand (1998) suggested four typologies[9], rather than a dichotomous typology, to explain cultural differences in values and behaviours.

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[9] The four-way typology constitutes vertical-self collectivism (e.g. China), vertical-self individualism (e.g. France), horizontal-self collectivism (e.g. kibbutz), and horizontal-self individualism (e.g. Norway). Vertical and horizontal relationship refers to authoritarian and equality-

2.6   Korean Perspectives on Mental Health and Mental Ill-Health

Early 'cultural' psychiatry was known to have begun with colonisation. Culture-specific symptoms were often viewed as 'exotic', if not peculiar, in the eyes of the colonialists. The value-laden observation and analysis of psychological symptoms and psychiatric experiences of the 'others' were often judged as irrational by the colonialists. This colonist psychiatry period demonstrated how cultural-insensitivity and ignorance could overlook the context and distort the meaning of cultural phenomena (Kirmayer & Minas, 2000). Even modern psychiatry was not value-natural, as psychiatric instruments were mostly developed in the Western-based medical society. Therefore, a diagnostic assessment or illness treatment might not always be universally appropriate and acceptable (Kirmayer & Minas, 2000). As Galanti (2003) observed, for example, perceiving traditional treatment methods of Asian cultures as inferior to or alternative to Western medical practices would be another form of cultural imperialism.

Understanding the cultural constructs of experiences of mental illnesses would help understand and accurately assess the mental health of Korean immigrants (Cheung, Leong, & Ben-Parath, 2003). Experiences of ill-health were culture-bound phenomena[10]. Definitions, the understanding of causation, and treatments for a

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based inter-personal relations. For example, vertical self collectivism can be found in a political system emphasising neither equality nor freedom. Vertical self individualism political system would value freedom, but not equality. A horizontal self collectivism political system values freedom, but not equality. Finally, a horizontal self individualism political system would value both freedom and the equality of its members (Rokeach, cited in Triandis & Gelfand, 1998).

[10] For example, Hwa-Byung', which literally means 'anger' or 'fire'-'illness, was recognised as a "Korean folk syndrome attributed to the suppression of anger" by DSM-IV (American

similar illness could vary among different cultures. As for other social behaviours, illness experiences involved a value system that was imbedded in a given cultural, historical, and societal context (Uehara, Farwell, Yamashiro, & Smukler, 2002). Personal illness experiences would be reflected and expressed by a set of lexicon and behavioural norms that imply general perceptions of the illness which were developed within a specific cultural and societal context (Uehara, Farwell, Yamashiro & Smukler, 2002). Therefore, it is essential to understand the cultural and societal aspects of an illness phenomenon to construct a valid assessment and treatment for multicultural clients (Uehara et al., 2002; Zane & Yeh, 2002). How a certain illness was defined and explained in a patient's culture and language could provide critical information for examining and treating the patient (Sue & Sue, 1987).

A general perception and concept of health and illness, such as definitions and interpretations, might not be identical across different cultures (Brown et al., 2003; Choi et al., 2002; Jang, Small, & Haley, 2001; Donnelly, 2001; Kagawa-Singer & Chung, 2002; Kim MY., 1994; Leong, Okazaki, & Tak, 2003; Noh S., Avison, & Kaspar, 1992; Selvaraj, 2001; Shin JK, 2002; Sue & Sue, 1987; Tseng, 2004; Wong & Tsang, 2004; Yamashiro & Matzuoka, 2001). For example, an identical symptom

Psychological Association Diagnostic Statistical Manual of Mental Disorders IV, p.846) (Brown et al., 2003; Lee M, 2004; Lin, Laun, Yamamoto, Zheng, Kim, Cho & Nakasaki, 1992; Pang, 1990; Purnell & Kim, 2003). The symptoms of Hwa-Byung were very similar to those of mental illnesses— insomnia, fatigue, panic, fear of impending death, dysphoric affect, indigestion, anorexia, dyspnea, palpitations, generalised aches and pain, and a feeling of a mass in the epigastrium (DSM-IV). The etiology and symptomology of Hwa-Byung were observed either as a culturally acceptable way to complain about psychological distress or a result of prolonged and suppressed negative emotions (Change SY & Meyers, 1997; McMinn et al., 2001; Pang, 1990; Park YJ, Kim HS, Schewartz-Barcott, Kim JW, 2002; Park YJ, Kim HS, Kang HC & Kim JW, 200,1Yoo, YG, 2002). Some recognised Hwa-Byung as a Korean-equivalent of Western depression (Brown et al., 2003; Lin, Lau, Yamamoto, Zheng, Kim HS, Cho, KH, Nakasaki, 1992; Pang, 2004).

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could have different labellings in various cultures (Jang et al., 2001; Kawaga-Singer & Chung, 2002). In other cases, an identical illness may be recognised and expressed by different symptoms (Brown et al., 2003; Leong, 1986; Yamashiro & Matsuoka, 2001; Sue & Sue, 1987). Accordingly, different methods of treatment might be suggested for a medically identical illness often due to culturally different causative explanations (Brown et al., 2003; Choi et al., 2002; Donnelly, 2001; Kagawa-Singer & Chung, 2002; Shin JK., 2002; Tracey, Leong, & Glidden, 1986; Tseng, 2004). In short, overall illness behaviour and the illness experience could differ from culture to culture, let alone individual differences even within the same cultural context of illness (Brown et al., 2003; Kim MY., 1994; Selvaraj, 2001; Shin JK., 2002).

A definition of what is a mentally 'healthy' state does not only have cultural, but also political and social connotations. The state of being 'healthy', which includes how people 'should' think, feel, behave, and live to be normal, often involves the ideology of the given time period under a certain political regime. A society held a 'pre'-scribed norm system that determined whether certain behaviours were normal or abnormal (Kagawa-Singer & Chung, 2002). For example, the U.S. Surgeon General explains characteristic of mental health as "successful performance, productive activities, fulfilling relationships, and contribution to the community or society" (Wong & Tsang, 2004). As Wong & Tsang (2004) argues, such a statement is value-laden, reflecting the Northern American value of individual achievement.

Wong & Tsang (2004)'s study found that Asian immigrant women's definition of mental health and illness were more multi-dimensional and political in nature than medical or somatic. Most women explain their experiences of mental illness as a simultaneous interaction of body and mind. The women's account of mental

illnesses does not fit neatly into the prevalent 'Asian' descriptions. In fact, the women's accounts of illness experiences were delivered in a variant of structures, elements, and emphases (Wong & Tsang, 2004). For example, contrary to the 'general' Asian characteristics of 'harmony' and 'sacrifice', the women in the study emphasised autonomy, self-development, and self-confidence as key elements for sound mental health. The tension which might generate psychological distress was found in a conflict between politically (and traditionally) imposed conformity and the modern woman's desire for success and individual achievement (Wong & Tsang, 2004). Wong & Tsang (2004) argue that the universalised perception of Asian culture would not capture the genuine and unique illness behaviours and experiences of Asian women's mental health/illness who resided contemporarily. Studies in the US also found a difference in severity in mental illnesses among various Asian ethic groups (summed by Kim BSK et al., 2001). Kim WS's (2003) study shows that the respondents —who had different Asian backgrounds such as Chinese, Filipino, Japanese, Korean, Miens, Cambodians, Laotians, and Vietnamese—had unique symptom patterns upon experiencing psychological distress. Multi-culturalism should not be structured and built on the pillar of cultural generalisation and collective understanding of non-main stream (in this context, Asian) cultures.

Generally, alcohol abuse disorder is more common in Whites than Asians. However, studies found a high alcohol dependency rate among Korean male immigrants—even equivalent to that of Americans (Muczak et al., 2004; Paniagua, 1998; Selvaraj, 2001; Yamamoto, Rhee & Chang, 1994). For many Korean people, substance abuse—especially alcohol addiction—, excessive gambling, family abuse, or other dysfunctional behaviours might not be perceived as mental illnesses (Kim MJ, Cho HI, Cheon-klesig, Gerace & Camilleri, 2002; Selvaraj, 2001). While those issues could be treated as 'taboo' and shameful, they might not be viewed as a condition in

need of medical/professional intervention (for example, counselling or other professional support). Men's alcohol abuse and the resulting domestic violence could also be perceived as a 'private matter' and Korean society would have more acceptance and tolerance towards such issues compared with Western society (Lee M., 2004; Selvaraj, 2001). Song's (cited in Purnell & Kim, 2003) study of Korean women's conceptions about domestic violence found that most of the participants did not consider verbal and psychological abuse from their husband as spousal battering. Others found that for most of the women experiencing depressive symptoms, they might not perceive or accept such symptoms as 'illnesses' (Brown et al., 2003). They would consider such symptoms as a normal part of life and would not consider consulting medical professionals.

'Mental illness' had often been equated with 'craziness' and 'total incapability' in Korea (Donnelly, 2001; Shin S, 2004; Yoo YG, 2002). Some might attribute such illnesses to 'demonisation', 'punishment' or 'curse in the family'—often believed to be due to their ancestors' bad deed (Ho, Rasheed, & Rasheed, 2004; Parnell & Kim, 2003). Accordingly, the term 'mental illness' itself could bear a strong stigma and discrimination towards families of a patient, as well as the patient her/himself. Within this context, it became responsibility of, and at the same time, burden on family members to provide care for their mentally ill family member (Donnelly, 2001; Paniagua, 1998; Watari & Gatz, 2004). Studies found that Korean-Americans with mental illnesses showed a stronger family-affiliative tendency and weaker social initiation compared to other ethnic groups (Bae SW& Brekke, 2002; Bae SW & Kung WW, 2000; Kim MJ et al., 2002; Leong, 1986; Watari & Gatz, 2004). The deep-rooted philosophical paradigms discussed in the previous section could influence people to accept a mental illness as a hardship through which one should achieve maturity and spirituality (Donnelly, 2001; Taylor et al., 2004).

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In general, traditional Korean medicine looks at the causes of illness in two ways: lack of 'ki' (a Western equivalent of energy or a Chinese equivalent of 'ch'i' or 'qi'); or/and an imbalance of 'eum' (a Chinese equivalent of 'yin') and 'yang'.[11] Traditional Korean medicine did not separate mind from body (or body from mind). It was believed that the bodily state and the mental state were closely intertwined, and therefore, treatment of an illness should target both mind and body at the same time. Accordingly, Korean people might attribute their discomforting experiences to the breakdown of 'ki' or 'yin and yang'. For those who look at the causes of their illness in a traditional way, it would be natural to consult Korean traditional doctors to solve their problems. Due to the perceived shared-belief in the etiology of illness, patients could find it more comfortable to talk about their illness with traditional Korean doctors than with Western medical professionals to regain the balance of energy (or 'ki'), as many Koreans believe the cause of their illness is the breakdown of 'ki' or 'yin' and 'yang') (Kim MY, Han HR, Kim KB, & Duong, 2002; Selvaraj, 2001; Shin SK & Lukens, 2002).

In other cases and arguably related to the prevalence of the somatisation tendency, Korean people might turn to general practitioners upon experiencing psychological distress (Akutsu, Snowden & Organista, 1996; Atkinson & Gim RH, 1989). Somatisation, by definition, refers to the expression of physically discomforting symptoms for which there is no medical diagnosis (Keyes & Ryff, 2003). Compared with some Western cultures where depression is often expressed in affective

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[11] Interestingly, Galanti (2003) analysed the 'oriental' medical etiology of yin and yang as Western equivalent of stress and illnesses. Stress was often known as a cause for various illnesses in Western medicine, and Galanti (2003) identified the 'imbalance of yin and yang' with the Western concept of stress.

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complaints, many Asian cultures—including the Korean culture —would express the identical medical illness through physically discomforting symptoms (Yoo & Skovholt, 2001). However, there are different interpretations or manifestations of somatisation: people might intentionally resort to physical complaints to avoid the stigma attached to mental problems; somatisation could be an aggregated form of psychological distress while such distress was suppressed (whether influenced by stoicism or avoidance of discrimination) until it affected the body; somatisation was an Asian variant of Western mental illnesses, particularly depression[12]; or somatisation was developed as linguistic 'idioms of distress' that reflected cultural values (Brown et al., 2003; Chang SY & Meyers, 1997; Choi et al., 2002; Keyes & Ryff, 2003; Kim MJ, 2002; McMinn et al., 2001; Leong, Okazaki & Tak, 2003; Purnell & Kim, 2003; Sue & Sue, 1987; Tseng, 2004; Vandervoort et al., 1999; Yoo & Skvholt, 2001).

Some pointed out the importance of understanding the cultural impact on the construct of the self to examine and analyse the psychopathology of people from a certain ethnicity and culture (Okazaki, 1997; Wong, Kim BS, Zane, Kim IJ, & Huang, 2003). The higher prevalence of social anxiety among Asian people was explained by the Asian pattern of self-construal. The self-construal of Asian people was analysed as being interdependent; identification and self-value of Asian people were determined through relationships with other people and how they could harmonise with others (Okazaki, 1987). A settling in process in a new society could be very demanding and immigrants are often required to adjust quickly and to adapt

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[12] Strong correlation between depression and somatic symptoms was found in studies on Korean Americans. Headaches, back pain, indigestion, stomach pain, dizziness, insomnia, muscle pin, change in appetite, and feeling energy-less and tired were some of the most popular somatisations (Choi et al., 2002; Keyes & Ryff, 2003; Kim MY, 1994; Kim YS, 2002; Shin JK, 2002; Sue & Sue, 1987; Yoo & Skovholt, 2001; Yoo YG, 2002).

themselves to a new environment. People with interdependent self-construal might feel more distress and isolation while struggling to form stable personal relationships and be accepted in a new society (Okazaki, 1987). The interdependent self-construal could also explain the commonly endorsed help-seeking pattern of Asians; informal help including self-help or within-family resolution. As people with the interdependent self-construal would be more concerned and sensitive about others' judgement and ideas on selves, they might be reluctant to expose their problems to others. People characterised by interdependent self-construal might also hesitate to ask others for help because they would not want to burden others and break the harmony with such people (Constantine et al., 2004; Okazaki, 1987).

However, the 'Korean' perception of illnesses discusses above might risk misunderstanding and misdiagnosis, and consequently, the incorrect treatment of Korean immigrants experiencing psychological difficulties (Stuart, 2004). Wong & Tsang's (2004) study of "when Asian immigrant women speak" is noteworthy as the study reaches further than the mere generalisation of Asian cultures. The study challenges the conventional and generally accepted understanding of 'Asian'-ism such as collectivism, familism, somatisation, Buddhism, and Confucianism, just to name a few. The study points out the possible pitfalls of the using the lump sum word 'Asian' to describe and understand multi-cultural aspects of mental illnesses. For example, somatisation, one of the most prominent 'Asian-exclusive' characteristics—was in fact commonly espoused during the Victorian era of history—, and was observed as a universal phenomenon (Jang et al., 2001; Kleinman, cited in Wong & Tsang, 2004; Wierzbicka, 1999). One step further, the North-American way of expressing distress could be viewed as and named 'psycholisation', as opposed to 'somatisation.'

2.7   *Social rather than Professional: Commonly Known 'Korean' Copying Strategies*

Noh & Kaspar (2003) argue that coping strategy adopted to deal with a stressful situation would result in a different state of mental health. For example, while active and problem-focused would be more effective in reducing stress level, passive and emotion-focused strategy might not bear a positive consequence (Noh & Kaspar, 2003). However, factors that determine the choice of strategy are culturally and situation bound—cultural and social context, nature of stressor, and social resource—which deserves a fair amount of recognition and attention (Noh & Kaspar, 2003). Watari & Gatz (2004) identify two main factors affecting people's help-seeking behaviours upon experiencing psychological distress and mental ill-health: cultural and structural. The former refers to a culturally constructed value, belief, and behavioural system. The latter includes language, knowledge and familiarity with service, finance, assessment and treatment options involved in accessing and utilising available services. The following two sections (part four and five of the literature review) discuss how those two aspects could impact on help-seeking patterns of Korean immigrants.

Rapid economic and political development in Korea has challenged some of the traditional social structures and cultural values (Purnell & Kim, 2003). However, some of traditional behavioural patterns still remain in people's value systems. Accordingly, the choice of copying strategies upon experiencing psychological distress might differ for Asians from other ethnicities (Yamashiro & Mastuoka, 2001). Preference of self or informal support to professional health services upon experiencing psychological difficulties reflects traditional Korean cultural values (Bae SH et al., 2003).

The notion of 'saving face' is a key factor in understanding interpersonal dynamics in some of Asian cultures (Zane & Yeh, 2002). This important notion is found in commonly used phrases in Korean language[13], as 'face' implies individual identity and societal position within the context of social norms and acceptance. The notion of 'face' applies not only to an individual, but also extends to the group that a person belonged to. As mental illness had been a stigmatising issue itself, and therefore, families of a person with mental illness(s) were often also a target of stigma and discrimination. Therefore, a family might also suffer pain and shame as mental illness would be perceived as dishonour to the family (Donnelly, 2001; Sue, 1994; Sue & Sue, 1987)—causes of which were believed to be 'demonisation', 'karma'[14], or 'a curse on the family'.

Reliance on social networks and informal help is often reported as a 'Korean' copying strategy (Chandras et al, 2000; Chang SY & Meyers, 1997; Constantine et al., 2004; Lee MS., Crittenden, Yu, E., 1996; Noh & Kaspar, 2003; Selvaraj, 2001; Shin JY, Berkson & Crittenden, 2000; Yeh & Inose, 2002; Yeh & Wang, 2000). Korean people would feel more appropriate to reach for close people—especially families—when experiencing emotional/psychological distress (Akutsu, Snowden, &

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[13] For example, "he has an iron board on his face" is an expression used when criticising someone for having no shame or dignity. "She coloured her family's face in black ink" means she did something that disgraceful and consequently ruined the reputation and dignity of her family.

[14] The concept of 'Karma' (originated from Buddhism) explained everything happening in the present life as a consequence of the previous life. Under the Buddhist influence, Korean people might believe that suffering from mental illnesses was their pre-determined fate to pay back their wrong-deed in the previous life. This fatalistic viewpoint on mental illnesses would explain 'passive' help-seeking behaviours of Korean people as they would 'accept' such suffering a deserving consequence. In addition to 'Karma', Buddhism believed the nature of life per se was suffering.

Organista, 1996; Chandras et al, 2000; Selvaraj, 2001; Tracey, Leong, Glidden, 1986). This informal approach to help-seeking would also save 'face' for their families and themselves against the shame and stigma associated with 'mental illnesses.' In addition to the general stigma attached to mental illnesses, people might fear that outsiders would view such illnesses as generic, which could ruin the name of ancestors while risking the future of offspring (Yamashiro & Matzuoka, 2001). In addition to the conceptual stigma associated with mental illnesses, Korean people could blame their lack of self-discipline for experiencing psychological distress. Within a culture where will-power is strongly emphasised and valued, perceived insufficient will-power could also cause personal shame[15] (Ahn T, Elizabeth & Tufts, 1980). This could partly explain why in Korean culture, personal difficulties and problems would stay within a family in order not to ruin the family name or face (Ahn T, Elizabeth, & Tufts, 1980; Kim BSK, Atkinson, & Yang, 1999; Kim MJ, 2002). Within the context, Korean families would often function as a self sufficient social unit in care-giving and it was found that people would turn to immediate family members first upon experiencing psychological difficulties (Shin JK, 2002; Yoo YG, 2002). Therefore, families were likely to be deeply involved in the process of the diagnosis of illnesses, caring, and decision-making for treatment (Bae SW & Kung WM, 2000; Kim MJ, 2002; Selvaraj, 2001; Watari & Gatz, 2004). The low rate of relevant service utilisation could be interpreted as another aspect of 'face'—or pride—saving behaviour of Korean people and collectivism.

While 'fatalism' and 'familism' would automatically put family on a care-giving spot in order to avoid negative perceptions from outsiders, such familial obligation and responsibility might become a burden on family members (Donelly, 2001; Youn, Knight, Jeong & Benton, 1999). It is often argued that families were the most

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[15] Confucianism seems to have affected the perception of self-will and shame.

effective resources in caring for people with mental illnesses (Donnelly, 2001). The role of families would be critical in the process of treatment and recovery. However, some (for example, Knight, Robinson, Longmire, Chun, Nakao, & Kim, 2002; Leong, 1986; Watari & Gatz, 2004) argue that familism, a feature of Asian collectivism, does not always have a positive effect either on a family member with mental illness(es) or other members who assume a care-giving role. Watari & Gatz's (2004) findings on Korean people with Alzheimer's disease show how 'familism' could have a negative affect on a person with such illness. The participants of the study would try to hide their symptoms from their families in order not to 'burden' them. In addition, loss of intelligent capability was perceived as a shameful experience especially in a (Korean) culture where seniority often represented authority[16]. Consequently, medical intervention and proper care would often be delayed (Watari & Gatz, 2004).

Okazaki (1999) found that treatment delay was significantly affected by perceived stigma by a patient's family members and by the severity of the illness. The treatment delay was longer when there was strong stigma perceived by family members. Criticism or hostility of family members would add to the deterioration of the mental health of patients (Bae SW & Kung WW, 2000; Sue & Sue, 1987). Furthermore, the 'family care' might delay receiving more effective professional treatment and deprive a patient of the chance for earlier recovery, which could result in later relapse (Bae SW & Kung WM, 2000; Selvaraj, 2001; Shin JK., 2002; Watari & Gatz, 2004). Other studies found that mental patients living with their families

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[16] Emphasis and un-conditional respect for authority is another influence of Confucianism. One of the Confucian principles explicitly teaches that there should be 'order' among people according to their age.

tended to have lower levels of "psychological differentiation"[17] (Ladipus et al., 2001) and more severe cases of mental illnesses as a result of delayed medical intervention (Watari & Gatz, 2004). In other words, those who live with their families were less able to cope with real-situations compared with other who live on their own. However, the onset of severe psychiatric symptom pressed for more timely service utilisation as such case could not be handled within a familial circle (Okazaki, 1999; Sue & Sue, 1987).

In a study on dementia care-giving families, Youn et al., (1999) found that while 'familism' was weaker in Korean Americans, the burden of providing family care amounted to the same degree. In other words, 'familism' did not alleviate the pain of family members or reduce the burden as a care-giver. Youn et al. (1999) suggested that Korean immigrants might feel guilty of 'feeling burdened', which aggravates their stress as caregivers. Other studies also observe the 'care-giving distress' especially among female Korean immigrants as they are often expected to provide care to their parent-in-laws (summed by Youn et al., 1999).

Other aspects of Korean culture might influence a patient to deny familial support, opting for self-help. Cultural appreciation in 'silence' and 'self-containment' seems to be linked with a 'keeping to oneself' strategy commonly espoused among Korean immigrants (Yeh & Inose, 2002). 'Talking less' and 'self-containment of emotions' were valued in Korean culture (Atkinson & Gim RH, 1989; Atkinson, Lowe, & Matthews, 1995; Bae SW & Kung WW, 2000; Chandras et al., 2000; Kim MY,

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[17] High differentiation was associated with self-confidence, self-defensive structure, independence, and intellectual development, while low differentiation was associated with repression, denial, under-controlled activity, and dependency (Ladipus, cited in Ladipus, Shin SK & Hutton, 2001).

1994; Pang, 1990). Confucianism and Buddhism praised and pursued certain individual characteristics such as selflessness, self-discipline, and patience. The solitary coping strategy also reflects cultural appreciation and emphasis on 'willpower.' Self-resilience, including controlling and suppressing one's own feelings, was often perceived as a symbol of maturity in Korean culture (Chang CS & Chang NJ, 1994; Shin JK., 2002; Talyor et al., 2004). For example, a study reported that the experience of psychological distress iss considered as self-controllable, rather than requiring medically attentive condition (Pang, 2004). Research even found European Americans to be more willing to ask for and receive support from social network than Asian Americans (summed by Taylor et al., 2004). Utilisation of social network was not as common in Asian Americans as it was in European Americans (Taylor et al., 2004). Self-concealment of personal difficulties, collectivistic nature, and introverted characteristic of Korean communication style might also discourage approaching and initiating available social support systems (Constantine et al., 2004; Taylor et al., 2004; Watari & Gatz, 2004). Korean people could be reluctant to 'utilise' and rely on their social network in order not to 'break the harmony' of a group and not to impose a favour or demand on close people (Constantine et al., 2004; Ho, Rasheed, & Rasheed, 2004; Taylor et al., 2004; Watari & Gatz, 2004). Such cultural values might function as restraining factors for individuals to seek even informal help, which could involve perceived intrusion with regard to the time, energy, and resources (Ho, Rasheed, & Rasheed, 2004) of others

Without adequate information about available health services, the 'self-help' coping strategy might be adopted to free other family members from shame and burden. Meanwhile, however, such strategy could gradually worsen the sufferer's condition. The possible harm of the solitary and self-dependency strategy was that while it might alleviate symptoms for a short time, it would eventually aggravate the mental

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wellbeing of the sufferer inducing further health deteriorations such as substance—alcohol, smoking, for instance—abuse (Shin JK., 2002; Taylor et al., 2004). Given already high-rate of alcohol consumption among Korean males, and considering 'cultural' patience and generosity on males' binge drinking, the issue of potential substance abuse raises a concern (Lee M, 2004; Purnell & Kim S, 2003). Self-sufferers of substance abuse problem might turn to other behavioural or addiction problems such as gambling, if substance abuse is not resolved at an early stage (Saevaraj, 2001). In fact, the WDHB (2002) reports that gambling received the highest level of concern from Korean immigrants among other health-related problems. In their study of depression coping strategy of Korean immigrant women, Um & Dancey (1999) found that some women would try to 'ignore their distress' by 'working even harder' around the house upon experiencing mental stress. While other women who 'talked about' their stress with their spouses reduced their stress level, depressive symptoms worsened among those who 'kept it themselves'[18].

Some Korean might find it awkward or inappropriate to 'complain' about their situations or experiences to other people, especially to a stranger (such as mental health professionals) (Bae SH et al., 2003; Paniagua, 1998). Some argue that 'perceived' and 'assumed' social support are more meaningful for Korean immigrants than actual receipt of practical help from close others. However, hesitation in asking for social support is also related to the under-utilisation of mental health services among Koreans (Taylor et al., 2004). Cultural reluctance to expose oneself to others could apply even to close people or social network, let alone mental

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[18] However, the result of Um & Dancey's (1999) study could be understood in a family structure context. Women would more likely to discuss their problems with their spouses in a family with 'liberal' atmosphere. On the contrary, within a rigid patriarchal environment, wives would find it even harder and uncomfortable to talk about their stress.

health professionals. As social network can function as an initiator and supporter for accessing professional help, blocking oneself form social support would lessen the possibility of informal referral to appropriate professional help.

Koreans might access traditional (oriental) doctors upon experiencing psychological problems (Akutsu, Snowden, & Organista, 1996; Donnelly, 2001). Combination of Western medicine and traditional treatment is also a common coping strategy adopted in Korean community (Kim MY et al., 2002). However, prolonged care within family[19] and traditional treatment delay timely intervention of professional mental health services, which might partly explain the under-utilisation of professional services among Korean people (Bae SW & Kung WW, 2000; Okazaki, 1999; Shin JK., 2002; Watanari & Gatz, 2004).

Dependency on religion is also more prevalent among Korea immigrants compared with other Asian groups in US (Bae SW & Kung WW, 2000; Selvaraj, 2001; Shin JK, 2002; Watari & Gatz, 2004; Yeh & Inose, 2002; Yeh & Wang, 2000). For those religious people, experiencing psychological disturbance might be interpreted as lack of spirituality and insufficient religious practices (McMinn et al., 2001; Paniagua, 1998). As not all religious leaders would make a clear distinction between demonisation and mental illnesses, people who would consult the leaders might conclude that they were 'possessed' (Southard & Southard, 1986).

Shin JK (2002) observed there were four stages for Korean help-seeking strategies: first, solitary coping; second, informal support; third, primary health care; fourth;

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[19] Many Korean people with mental illnesses lived with their families (Shin SK, 2004).

mental health professionals. Professional help-seeking was often delayed[20] as 'the last resort'—usually when symptoms became noticeable to outsiders—, which correlates with the under-utilisation phenomenon among Korean immigrants (Okazaki, 1999; Yoo & Skovholt, 2001). Utilisation of General Practitioner and the delayed approach to professional mental health services could be related to somatisation of psychological distress (Hong GK, 1988; Kim YS, 2002; Shin JK, 2002; Sue & Sue, 1987; Watari & Gatz, 2004; Yoo & Skovholt, 2001). Professional mental health services were accessed only after experiencing excessive somatic symptoms or when illnesses reached a serious stage where they could not be managed or controlled within the informal boundary of people (Chandras et al., 2000; Shin JK, 2002; Yamashiro & Matsuoka, 2001).

2.8   *Cultural and Structural Barriers in Utilising Professional Mental Health Services*

Structures, systems, and underlying paradigms are socially constructed institutions. They are influenced by, and at the same time influence political and cultural atmospheres of society at the given time. The phenomenon of globalisation and increased international mobilisation has brought a new challenge to mental health professionals worldwide, and perhaps more to those in multi-cultural societies such as New Zealand. Chiu (1996) identified three major challenges mental health professionals encounter in a multi-cultural society: mental illnesses are universal phenomena throughout various cultures and ethnicities; the challenging nature of immigration progress put immigrants in a vulnerable situation; and cultural illness behaviours vary, which includes definition, cause, symptoms, and help-seeking

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[20] Average of 5.3 years were spent for Korean immigrants to access mental health professionals after the recognition of their problem (Shin JK, 2002).

pattern and expected treatment. This section introduces plausible explanations for the phenomenon of the under-utilisation phenomenon among the Korean population, focusing on the assessment and treatment options of main stream mental health services.

As discussed earlier, Asians in general were found to delay proper treatment until reaching a severe stage and then terminating treatment at an early stage (Atkinson & Gim RH, 1989; Brown et al., 2003; Chandras et al., 2000; Leong, 1986; Sue, 1994; Zane et al, 1994). This phenomenon of under-utilisation, associated with severely damaged mental health states upon accessing professional services, required societal attention as timely intervention and treatment were critical in treating mental illnesses as well as physical illnesses (Shin JK, 2002; Sue & Sue, 1987).

2.8.1 Cultural Sensitivity

Lack of cultural sensitivity in main stream mental health services was noted as a major factor for under-utilisation (Akutsu, Snowden, & Organista, 1996; Atkinson & Gim RH, 1989; Atkinson, Lowe, & Matthews, 1995; Bae SW & Kung WW, 2000; Brown et al., 2003; Chandras et al., 2000; Chang SY & Meyers, 1997; Constantine et al., 2004; Donnelly, 2001; Heah, 1998; Kim MJ, 2002; Kim MY, 1994; Lee SSW, 2004; Okazaki, 1999; 1994; Selvaraj, 2001; Shin JK., 2002; Shin SK & Lukens, 2002; Sue, 1994; Yeh & Inose, 2002; Yoo YG, 2002). Even when people accessed relevant services, insufficient cultural sensitivity of assessment and treatment instruments would create doubt concerning the credibility of services among clients, which could lead to earlier termination and ineffective outcomes of treatment (Constantine et al., 2004; Wong et al., 2003).

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Sue & Sue (1987) claim that the failure to acknowledge cultural factors including differences in the concept of illness could generate communication breakdown between mental health clients and professional service providers. Behaviour patterns and value systems of holders are often the results of cultural construct; people learned what was or was not normal within cultural paradigms (Gunsalus & Kelly, 2001). In a multi-cultural setting, such as in New Zealand, the lack of available and valid explanation and understanding in bi-cultural experiences of immigrants could be a major source of bias and mis-diagnosis (Paniagua, 1998; Zane & Yeh, 2002). Misdiagnosis would subsequently lead to inappropriate options for medical interventions.

As Sue (1994) argues, the complexity of variables within the diversity of Asian culture's' should be considered in assessing and treating Asian clients. The reliability and validity of Western-developed psychiatric measures were questioned by many researchers (for example: Choi et al.'s (2002) study of the DSM Scale for Depression[21]; Gunsalus & Kelly's (2001) study of the Millon Clinical Multiaxial Inventory III; Jang et al.'s (2001) evaluation of the Geriatric Depression Scales; Joo EJ, Joo YE, Hong, Hwang, Maeng, Han, Yang, Lee & Kim's (2004) evaluation of the Korean version of the Diagnostic Interview for Genetic Studies; Noh S et al.'s (1992)'s study of the Center for Epidemiologic Studies-Depressive Scale; Wong et al.'s (2003) examination of cognitive therapy and time-limited dynamic psychotherapy). Most of these studies confirm the reliability and validity of Western psychiatric instruments to a certain degree. And yet, they also recommended adding culture-specific scales to existing psychiatric instruments or combining different

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[21] Diagnostic and Statistical Manual of Mental Disorders developed by American Psychiatric Association.

instruments. For assessment and treatment, relation-centred constructs would acknowledge the characteristics of collectivism and familism, and therefore, could bear more effective outcomes than individual-centred ones (Zane & Yeh, 2002).

2.8.2 *Socio-cultural Linguistics*

Conceptions, symptoms and expressions of illness might not necessarily be identical in different cultures (Cheung, Leong, & Ben-Porath, 2003; Leong et al., 2003; Noh S, 1992). Therefore, a cross-cultural validity of psychiatric assessment would be hard to be achieved when the assessment failed to measure the same concept (Cheugn, Leong, & Ben-Porath, 2003; Jang et al., 2001; Leong et al., 2003; Leong, 1986; Mui, 2001; Noh et al., 1992). Cultural sensitivity would also include availability of bi-lingual services. Language was often noted as one of the determinant factors of mental health service utilisation pattern (Akutsu, Snowden, & Organista, 1996; APHPR, 2003; Atkinson & Gim RH, 1989; Bae SW & Kung WW, 2000; Berry et al., 1987; Brown et al., 2003; Constantine et al., 2004; Donnelly, 2001; Kim MJ et al., 2002; Lee SSW, 2004; Yamashiro & Matsuoka, 2001; Selvaraj, 2001; Shin JK, 2002; Sue, 1994; Won, Krajicek & Lee, 2004; Yeh & Inose, 2002). Language is not a mere assembly of mechanical elements; language reflects the given culture. Therefore, verbal communication would often involved non-verbal linguistic features that were not necessarily universally identical (Chiu, 1996). As Tseng (2004) pointed out, the breakdown of communication could occur even among people from the same linguistic background. The provision of bilingual services might require more than a technical translation and interpretation (Bae SW & Kung WW, 2000; Leong et al., 2003; Leong, 1986). Technical translation/interpretation might not always deliver complicated layers of meanings and expressions associated with the nature and features of psychiatric symptoms, causing misunderstanding between a client and a

professional (Leong et al., 2003; Leong, 1986; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Translation had its limit especially when equivalent word or expression could not be applied to assessment instruments (Jang et al., 2001; Noh S, Wu, Speechley & Kaspar, 1992b). In addition, a client might not feel comfortable sharing private experiences with a translator (Sue & Sue, 1987).

Even with a 'perfect' translation, the interpretation of a question and response might not be compatible between clients and professional service providers who do not share the same cultural and linguistic background (Jang et al., 2001). For example, Gunsalus & Kelly (2001) observe that Korean-typical characteristics—often referred to as collectivistic—might be interpreted as "emotionally dependent, lacking in social skills, other-oriented, and passive" when assessed with a Western-developed psychiatric instrument. After examining the Center for Epidemic Studies-Depression Scale, Noh et al. (1992a; b) found that certain criteria of symptoms were non-applicable to Korean immigrants. For instance, the items designed to evaluate the "Positive Affect" involved questions (such as "feeling as good as other people", "was happy", "enjoyed life", and "hopeful about the future") that would be unlikely to receive positive responses from immigrants under settlement pressure. Certain personal characteristics more prevalent among Korean people could also result in 'negative' results. Cultural emphasis on modesty and self-restraint might collide with self-admission of 'good feelings' (Okazaki, 2002). If so, a 'normal' Korean might be diagnosed as having 'abnormal' personality or 'dysphoric' symptoms which would require profession intervention.

Not every culture shares the same value system of virtue and vice (Chiu, 1996). For example, a Korean respondent might say he or she is satisfied with his/her life when it was not exactly the case. If an examiner was not aware of the cultural emphasis on

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modesty and moderation, the response might not be assessed accurately. Under the influence of Buddhism, Confucianism, Taoism, and cultural stoicism, Korean people might choose not to express what they really feel inside. Naturally, culturally insensitive and inadequate measurement might result in misdiagnosis (under or over) (Galanti, 2003; Gunsalus & Kelly, 2001, Choi et al., 2002; Jang et al., 2001; Purnell & Kim, 2003; Sue & Sue, 1987; Yoo & Skovholt, 2001). Lack of cultural understanding and inadequate bi-lingual services[22] would result in invalid assessment and therefore, inappropriate treatment (Paniagua, 1998). Prudent analysis of psychiatric instruments, followed by careful examination and analysis of responses would be essential to avoid misdiagnosis and consequently inappropriate treatment (Noh S et al, 1992 a; b).

2.8.3   Familiarity and Compatibility with Mainstream Services

Unfamiliarity with mental health services would hinder accessing and utilising proper services (Chandras et al., 2000; Donnelly, 2001; Kim MY, 1994; Shin SK, 2004; Shin SK. & Lukens, 2002; Tseng, 2004; Won et al., 2004; Yeh & Inose, 2002). People would not be able to access existing service facilities if they lacked information about the availability of such services. Unfamiliarity with the process of (Western) medical diagnosis and treatment would not favour clients from other cultural backgrounds (Atkinson & Gim RH, 1989; Bae SW & Kung WW, 2000; Chandras et al., 2000; Constantine et al., 2004; Lee SSW, 2004; Shin JK, 2002; Sue, 1994). Cultural collision might occur also during a treatment process (Gim RH.,

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[22] Studies found that the same group of 'multi-ethnic' clients were rated as having more severe psychological distress when assessed in their second language or by counsellors from the 'dominant' culture. When assessed in their first language or by a counsellor who were bi-lingual, the same people were evaluated as more normal and healthier (summed by Paniagua, 1998).

1989; Bae SW & Kung WW, 2000; Tracey, Leong, & Glidden, 1986). For example, the concept of 'counselling' might not be familiar to some Korean people (Selvaraj, 2001; Tseng, 2004), if not stigmatising (Galanti, 2003; Shin SK & Lukens, 2002). It was not until after the Korean War (1950s) that psychotherapy was first introduced in Korea. Before that, shamanism healing and traditional herbal medicine dominated healing mental illnesses. The concept of psychiatry and psychotherapy had become more common, and yet, psychotherapy might generally be considered as the last resort (Bae SH, Joo ES & Orlinsky, 2003). However, Bae SH et al. (2003) reported relatively more common utilisation of counselling services compared to other psychiatric facilities due to its non-medical and therefore less stigmatising nature.

In the counselling process, having been influenced by the culture where self-containment and silence were praised, Korean clients might perceive discussing personal experiences with a stranger (mental health professionals) as inappropriate and uncomfortable, especially when they feared potential dishonour (Kim I, 1981; Kim MJ, 2002; Ladipus et al., 2001; Leong, 1986; Okazaki, 1994; Paniagua, 1998; Shin JK, 2002; Yoo YG, 2002). The authors above also suggest that such cultural aspects of Korean people—restraint and reserve—might be misunderstood and interpreted as being passive, repressed, and non-compliance with a treatment process. McMinn et al. (2001) identifies Korean values observed in people seeking psychological support as; patience, endurance, privacy, and avoiding disclosure (pp.146). Service providers' knowledge of such cultural features would encourage Korean clients to seek and stay in appropriate medical services. Wong et al. (2003) claims that personality and world-view matches could bear more treatment compliance and effective treatment outcomes than ethnicity match of a client and a service provider.

When participating in counselling or accessing other psychotherapeutic services, studies reported that Korean clients preferred a directive, structured, and problem-solving session (Chang CY & Meyers, 1997; Kim BS, Ng & Ahn, 2005; Ladipus et al., 2001; Leong, 1986; Paniagua, 1998). Rather than sharing their history of psychological difficulties in search for the root of such emotional distress, they might expect a counsellor to act as an authority figure to give advice or a concrete solution on how to cope with distressing conditions (Bae SW & Kung WW, 2000; Chandras et al., 2000; Kim B, Ng, & Ahn, 2005; Ladipus et al., 2001; Leong, 1986).

Korean immigrants might have a different view on the etiology and pathology of illnesses from a Western society, as mind and body were inseparable entities in Korean culture. Klienman & Good (1985) claimed that such a holistic perspective on illnesses might explain why some Korean people would opt for appealing to physical symptoms rather than affective terms when describing emotional distress. In addition, prescribed Western bio-medication might not result in desirable treatment outcomes when a client believes a causation of illness was metaphysical and spiritual than medical (Galanti, 2003; Kagawa-Singer & Chung, 2002). Additional concern for pharmaceutical treatment involves a different drug metabolism among different ethnic groups which raises a concern for adjusting dosage of medication for clients from 'other' ethnicity (Panigua, 1998). Also, as traditional medicine was often a common treatment option among Korean clients, the possible impact of combination—either as side/negative or as synergic—of Western and Oriental medications should also be considered (Panigua, 1998). Studies suggested appreciation of a client's 'traditional' diagnosis and healing methods could facilitate treatment compliance because the 'tradition' would be something the client believed in and expected (Bae SW & Kung WW, 2000; Sue, 1994).

2.8.4   *Effective promotion for proper services*

Perhaps contrary to a general expectation, Shin JK (2002) found that upon accessing mental health services, Korean immigrants preferred utilising 'distant' facilities rather than ones located near their neighbourhood. Shin JK (2002) explains that such behaviour reflects the existing stigma attached to mental health issues. As such, cultural perception of mental illnesses could be a disincentive factor in accessing mental health services.

If so, adequate information about the nature of mental illness and treatment options may encourage accessing proper help in a timely manner. Familiarity with available services—such as location and treatment process—and cultural sensitivity of such services would also increase the utilisation rate by Korean clients. It was reported that culture-sensitive services reduced premature termination of treatment and increased service utilisation (Shin JK, 2002; Sue et al., 1991; Zane et al., 1994). Shared world view would provide both a client and a counsellor with a framework to understand illness behaviours and conduct proper psychiatric assessment and treatment (Galanti, 2003; Kim BS, Ng, & Ahn, 2005). On the contrary, a mis-match of worldview could result in attrition (a client's failure to return for therapy), premature termination of or non-compliance with treatment (Akutsu, Tsuru & Chu, 2004; Kim BS, Ng, & Ahn, 2005; Paniagua, 1998). A linguistic and culture/ethnicity match were found to be especially important in decreasing early termination of treatment and inducing effective treatment outcomes when clients had a lower level of linguistic fluency and acculturation (summed by Akutsu, Tsuru, & Chu, 2004; Sue et al., 1991). A gender and ethnicity match between a client and a counsellor also reduced the drop-out rates of ethnic minority groups (Sue et al., 1991).

Therefore, effectively promoting culturally-sensitive mental health services might require the availability of counsellors who have capacity to understand the cultural, ethnic, and contextual background of their clients (Chandras et al., 2000; summed by Sue et al., 1991). In a multi-cultural society like New Zealand, counsellors would also need to know the immigrant-specific problems such as racism, sexism, socio-economic struggling, and other adjustment and acculturation stresses (Chandras et al., 2000). Akutsu, Snowden, & Organista (1996) suggest that the bilingual and bicultural approach in promoting mental health services to immigrants would attract otherwise-hesitant and reluctant clients.

In addition to shared world-view, client's positive expectation for counselling outcomes was pointed out as positive factor for a successful multi-cultural counselling (Kim BS, Ng, & Ahn, 2005; Galanti, 2003). A positive attitude towards counselling would increase treatment compliance and encourage active participation in treatment (Fisher et al., cited in Kim BS, Ng, & Ahn, 2005). In addition to cultural and linguistic barriers, the shame and stigma attached to mental illnesses were also critical disincentives in seeking professional help (Atkinson & Gim RH, 1989; Atkinson, Lowe & Matthews, 1995; Bae SW & Kung WW, 2000; Brown et al., 2003; Constantine et al., 2004; Kim MY., 1994; Kim YS, 2002; Okazaki, 1999; Selvaraj, 2001; Shin JK, 2002; Shin SK & Lukens, 2002; Sue & Sue, 1987; Tseng, 2004). It was suggested that culture-specific and culture-sensitive psycho-education or mental health promotion could encourage people experiencing psychological difficulties to seek appropriate help as well as increasing treatment-compliance and treatment session attendance (Akutsu, Tsuru, & Chu, 2004).

Some claim that the phenomenon of the under-utilisation mainstream health services among minority ethnic population reflects the ineffective promotion of relevant

services (summed by Sue et al., 1991). Psychoeducation/mental health promotion could be effective as Sue et al.'s (1991) study found that although being shy from seeking professional help upon experiencing psychological difficulties, Asian people achieved effective treatment outcomes once they initiated professional help-seeking. Previous experience of mental health services utilisation was found to have a positive effect on the recognition and acceptance of psychological difficulties. Hence, people who once utilised professional mental health services would be more proactive in accessing appropriate help upon experiencing another psychological problem (Solberg et al., 1994).

Studies of psycho-education conducted to clients, families of clients, or general community reported positive outcomes: change in general attitudes towards mental illnesses; decreased stigma; alleviation of symptom severity; increased empowerment and self-resilience; more factual understandings about conditions; effective coping strategies; compliance with professional intervention; and positive outlook on recovery (Kim MJ et al., 2002; Shin SK, 2004; Shin SK & Lukens, 2002; Watari & Gatz, 1992). As discussed earlier, Korean people showed a preference for informal help such as family and other social network. However, close acquaintances of a potential client might lack knowledge about mental illnesses and might not know how to cope with such conditions (Bae SW & Kung WW, 2000). In this respect, family- and community-based mental health promotion would encourage and empower significant others to refer and support their friends and family members to seek appropriate help in a timely manner (Akutsu, Snowden, & Organista, 1996; Bae SW & Kung WW, 2000; Shin JK, 2002; Shin SK, 2004; Watari & Gatz, 2004). As religion played an important part in Korean immigrants' lives, psychological knowledge may encourage religious leaders to make a timely referral to proper mental health services (Yeh & Wang, 2000). Kim-Goh's (1993) study

shows that clergymen with psychological conceptions, rather than religious conceptions, of psychiatry were more willing to make a referral to professional mental health services. Community-based psycho-education could also develop co-ordination and a referral system between general health services and psychiatric service facilities (Hong GK, 1988; Kim MY, 1994; Selvaraj, 2001; Shin JK., 2002; Shin SK, 2004; Zane et al., 1994). Psychoeducation could also initiate social resources to function as an effective psychological support to deter manifestation of mental illness upon experiencing stressful events and to induce affective treatment outcomes (Bae SW & Kung WW, 2000; Noh & Avison, 1996).

Chapter 3:   Methodology

3.1   Research Question

The study aims to explore Korean-New Zealanders' experiences of psychological difficulties and mental ill health. The study concerns mainly two aspects of such experiences: how Korean-New Zealanders perceive and respond to their psychological/emotional difficulties; and what contributes to their experience. Hence, the purpose of the study is: to describe the participants' experiences of mentally and emotionally challenging moments in their immigration process and to explore factors and variables that influenced their experiences of mental/emotional difficulties. The individual participant's experience of mental/emotional struggles during their immigration process may differ from one another. However, by analysing individual participants' accounts of their real life experiences, the study intends to identify common aspects and features that may be shared by participants from different backgrounds.

As Uehara et al. (2002) explains, there are many factors and elements that constitute experiences of ill-health; how symptoms are noticed; how causations are explained; how people respond to such experiences; recommended treatments; and the linguistic elements used to describe such experiences.

For the purpose of the study, obtaining genuine and lived accounts of the participants' experiences are quintessential. To best receive, analyse, and deliver the genuine experiences of the participants, the study espouses transcendental phenomenology. A brief discussion on the paradigm of transcendental

phenomenology provides a theoretical and philosophical framework for the methodology utilised in the study.

3.2   *Why Phenomenology?*

The aim of the study is to record and investigate individual participants' accounts of their mentally and emotionally challenging experiences during an immigration process. In doing so, the study ultimately intends to identify and document shared themes of individual participants' reality; what and how they experienced and what constituted structural elements of such experiences.

Qualitative research methods, such as phenomenology adopted for the study, would prove advantages over quantitative methods for the aim of this study stated above. Most of the previous studies discussed in the literature review section were conducted outside the New Zealand context. In addition, not all the studies focused on Korean immigrants living in Western society. Subsequently, there is scant research that delivers 'grass-roots' voices of Korean-New Zealanders with experiences of psychological difficulties (as opposed to physical difficulties).

The amount and depth of the previous studies investigated for the study do not provide sufficient information for a deductive research approach. Limited amount of research on Korean-New Zealanders on the issue of mental health did not offer substantive data to form general principles of theoretical framework for a positivistic and deductive research approach (Tolich & Davidson, 2003b). It was not considered as 'scientific' to assume that research findings from other Western societies on 'Asian' immigration population should apply in the case of Korean-New Zealanders. After all, as Sagan (cited in Tolich & Davidson, 2003b) claimed, existing

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assumptions would need to be critically examined because authority and common sense should not guarantee ultimate truths. In addition, the aim of the study is to capture and document how particular experiences are reconstructed as meaningful reality by the participants, not 'counting' 'measurable' aspects of such experiences to 'predict' patterns of human behaviour (Tolich & Davidson, 2003a; 2003b).

Qualitative research methods appreciate both diversity of theories and different perspectives of the participants. They are also a powerful tool in observing and documenting the nature of reality as a starting point of research (Flick, cited in McNabb, 2002). Interpretative research approaches such as phenomenology provide a methodological framework within which a researcher can capture and investigate genuine and detailed understanding of social relationships that include people as agents of assigning meanings to their real-life experiences and thereby, constructing the reality (McNabb, 2002; Tolich & Davidson, 2003a). Therefore, phenomenology provides an optimal theoretical and methodological framework to document Korean-New Zealanders accounts of their experiences in a genuine and authentic mode.

The aim and the nature of the study entail various fields of society such as psychology and public policy. Personal interviewing is one of the mostly used methods in public policy research (McNabb, 2002). Unstructured interviewing adopted for the study is effective to avoid standardisation and generalisation in collecting and analysing lived-experiences of participants (Opie, 2003). Opie (2003) explains the strength of unstructured interviewing as an optimum method when researching on relatively under-researched subjects. Although the study adopted 'semi'-, rather than 'un'- structured interviewing technique in order to facilitate efficiency of each interview session (that is, the researcher prepared a list of questions she might want to focus on during each interview session), such a semi-structured interviewing strategy is still believed to benefit studying under-

documented Korean-New Zealanders' experience of mental health issues. The personal interviewing espoused for the study enables the researcher to probe during the data collection process and thereby, to adapt to each interview session and collect more complete information from the participants (Frankfort-Nachmias, Nachmias, 1996). As Bernard (2002) succinctly claimed, nothing could beat unstructured interviewing when studying the real life experiences of human beings.

All in all, the art of phenomenology is describing as real life experiences (or reality) and finding the essence (commonly appearing features) of such experiences (Carpenter, 2003; Giorgi & Giorgi, 2003; Moustakas, 1994). Experience refers to what and how a person perceives "objects, events, situations, and circumstances" as it appeared to their consciousness while engaging themselves in social interactions (Carpenter, 2003; Mezquita, 1993; Moustakas, 1994; Munhall, 1994; Saramtalps. 1993). In other words, 'reality' in phenomenology is a subjective experience constructed under an impact and on a continuation of verbal and behavioural communication between persons (Carpenter, 2003; Moustakas, 1994; Munhall, 1994; Sarantakos, 1993). While reality is a subjective experience (or phenomenon), phenomenological study aims to identify the essence—shared common themes—of individual experiences (Moustakas, 1994; Munhall, 1994). Phenomenology will enable the researcher to document the genuine description of the participants of the study (Mezquita, 1993).

3.3   Participants

3.3.1 Criteria for Participants

The study aims to deliver real life accounts of experiences of Korean-New Zealanders who have had a history of 'mild' psychological difficulties. For this aim,

purposive sampling was used in order to recruit participants with certain homogenous qualities (Smith & Osborn, 2004). 'Korean' refers to people who identify their ethnicity as Koreans. 'New Zealander' refers to people who had been living in New Zealand as their residential ground. 'Psychological difficulties' refers to experiencing emotional or mental distress or problems. Causes or symptoms of such difficulties were not specified during the recruitment process. Experiencing 'psychological difficulties' did not necessarily require an official diagnosis from mental health professionals. Having utilised a counselling service was considered as fitting into the category of experiencing psychological difficulties as opposed to 'physical' difficulties. 'Mild' was used in contrast to 'extreme' or 'severe'.

With regard to ethical and safety concerns, the researcher sought support from Korean mental health professionals to separate 'mild' cases from 'severe' cases. The topic of the study and the content that was to be shared by the participants during the interviews could potentially entail sensitive and personal issues For the participants, talking about their distressful experiences could trigger vulnerability and relapse into a psychologically challenging condition. As the researcher is not a mental health expert, it was convincing to seek professional judgement in selecting potential participants for the study in order to prevent or minimise possible distress the participants might feel by taking part in the study. It was crucial to interview only those who were 'healthy' and 'resilient' enough to talk about their experiences of psychological difficulties without feeling offended and experiencing conflicts.

The term 'mild' cases includes people who have recovered from their mental/emotional struggles—who had been capable of leading a productive life and who were 'healthy' enough to participate in an interview and share their personal experiences. The mental health professionals consulted distributed the participant

recruitment advertisement and the information sheet to their clients whose cases were 'mild' enough to participate in the study. The researcher also arranged for mental health support services to be available to the participants should they experience psychological discomfort beyond the normal level by participating in the interview sessions.

3.3.2 Locating Participants

First, due to the potentially sensitive nature of the study topic, the researcher contacted mental health services in the Auckland region. Some of the service agencies referred the researcher to mental health professionals—psychotherapists and counsellors—who had Korean clients. Secondly, the researcher contacted the mental health professionals to discuss the study and to seek support. Those who agreed to assist the researcher during the recruitment process examined the information sheet (Attached as Appendix A), the recruitment advertisement (Attached as Appendix B), and the interview schedule (questions to be asked during interview) (Attached as Appendix C). Thirdly, the participant recruitment advertisement and the information sheet were distributed through the supporting Korean counsellors to some of their Korean clients who had experienced mild psychological difficulties. The information sheet and the participant recruitment advertisement sheet provided potential participants of the study with the following: a brief introduction of the researcher; topic and purpose of the study; procedures involved in the study; rights of the participants; and the responsibility of the researcher. Two versions—in English, the dominant language spoken in New Zealand, and in Korean, the first language of potential participants—were prepared using lay language. Potential participants were asked to contact the researcher by email or telephone as provided in the information sheet and the recruitment

advertisement. As a result, six people contacted the researcher and expressed their interest in participating in the study. During the initial contacts the participants' right to withdraw from the interview or to refuse to answer interview questions was re-emphasised. The preferred method of interview was also discussed during the initial contacts. The researcher offered three choices to the participants; face-to-face interview (the participants meet the researcher in person for an interview); telephone interview (the participants engage in a telephone conversation with the researcher for an interview); and paper-to-paper interview (the participants answer the researcher's questions by providing their descriptions of the experience). The second and third choice would not require the participant to meet the researcher—a stranger—in person, which would enable them to keep their identity secure from the researcher while participating in the study. Five of the participants decided to meet the researcher in person and participate in the interview. During the initial contact with the researcher, they expressed their willingness to help other people in similar situations. The researcher also learned that all five the participants had overcome or were in the process of overcoming their difficulties. The participants told the researcher that their lives were in a stabilising stage. Venue and time for interview were decided following the participants' preferences. One of the participants expressed a preference for paper-to-paper method. Initial contact with this participant was made through telephone. The researcher explained the overall structure of questions designed, and emphasised that the prepared questions were provided just to guide the general direction of the study. The participant was encouraged to provide 'free-writing' accounts of the experience and not to be limited to exact wordings, phrases, and structure of the questions unless that was what they desired. The set of questions (which were identical to the set used in interviews) were sent to the participant by email. With this particular participant, the length of the answers was also discussed after the distribution of the set of questions. The

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researcher asked the participant to 'write whatever came to his or her mind' without being restricted by linguistic accuracy or the given question. The participant also wanted to have an exact 'time line'; by when the answers were expected by the researcher. After a brief telephone discussion, the participant and the researcher agreed on one-week period. To return the question to the researcher, the participant preferred sending the responses via email rather than using postal service for convenience.

3.3.3 Demographic Information of the Participants

Five of the participants were in their early to mid-thirties. Three of them were female and the other two were males. One of the six participants was a male in his fifties. All of them had been in New Zealand longer than three years. Two of the six participants were married. One was separated while the others were single. Three of them experienced depressive symptoms. Two of the other three experienced gambling addiction. One of the other three was the wife of an ex-gambling addict.

3.3.4 From Participants to Co-Researchers

The primary source of data for the study depended heavily on real life accounts of individual participants. The design of the study was based on the researcher's belief in the value of the participants' oral or written accounts of their experiences. There would not have been any experience to study had it not been for the participants' genuine and vivid accounts of their meaningful realities. The participants were the very agents of the phenomena that were explored and documented. Therefore, from hereafter, the participants were addressed as the co-researchers of the study

3.4 Preparation for Interview

3.4.1 Development of Guiding Questions for Semi-Structured Interview

A series of questions were prepared for semi-structured interviews (both in-person and written) (Attached as appendix C). The questions were phrased and organised in order to facilitate comprehensive and vivid accounts of the participants' lived experiences. The questions were also to assist both the researcher and the co-researchers focus on the main topics of the study. During the course of each interview, however, some of the original questions were rephrased, re-ordered, omitted, or repeated if required. Additional questions were also asked in order to clarify or to help—both the researcher and the participants—focus on the topic. The interviews were not restricted to the pre-pared set of questions; the co-researchers elaborated on subjects that were more meaningful for them. The researcher found the nature of semi-structured interview—variation and adaptation of the original questions in each interview sessions—effective to anchor interviews on personal subjects with different co-researchers.

In addition, the phenomena under investigation were under researched in New Zealand. The researcher believed that semi-structured interviewing method would help add value and richness to the existing data on experiences of psychological difficulties among Korean-New Zealanders (Opie, 2003).

3.4.2 Technical Matters

The five interviews conducted in a face-to-face manner were audio-taped using two separate sets of tape-recorders. This was to prevent any unfortunate or unforeseen

accident or mechanical glitch. After each interview session, the researcher wrote name (pseudonym was used) of co-researchers and series number on tapes for later identification. The date and venue of each interview were recorded in the researcher's personal notebook, along with brief notes the researcher took during the interview.

The written interview was done corresponding by e-mail and telephone conversation between the researcher and the co-researcher. The researcher sent the set of questions identical to the one used in in-person interviews via email. The co-researcher sent the responses through email as it was preferred to postal mailing. During the process, e-mail and phone were used also for the co-researcher to clarify questions asked in the questionnaire.

3.5   *The Interview*

Each interview was conducted in a venue and time of the co-researchers' preference.

All the co-researchers had at least a rough idea about the interview because they had been provided with the information sheet and the participant recruitment advertisement during the participant recruitment process. They did however express concern whether their story could be any of value and help to the study and the researcher. After a brief explanation about the nature of the research and the process of data collection, the co-researchers signed the Consent Form (Attached as Appendix D) to officially confirm their participation in the study.

After a brief social conversation, the researcher re-gained permission to use tape-recorders and to take notes during the face-to-face interviews. The co-researcher

signed the Authority For The Release Of Tape Transcripts (Attached as Appendix E), which stated their permission for the researcher to use the tape-recorded interviews for the research. The co-researchers did not seem to be too conscious of the presence of the tape-recorders. However, the researcher was not able to engage in note-taking as planned for a couple of reasons: first, the note-taking behaviour seemed to have decreased the level of received-'attention' perceived by the co-researchers. The note-taking required the researcher to temporarily decrease the level of rapport with the co-researchers as she had to seize the eye-contact in order to write something down on paper. The researcher's attention was also moved from the co-researchers to paper and her writing action. In addition, note-taking was similar to a power-off incident. After writing down a phrase or even a word, the researcher felt as if she had to switch on the power to be attentive to the co-researchers again; and the note-taking seemed to distract the co-researchers from their focus, as they would kindly and considerately pause or elaborately slow down their speech whenever the researcher started writing down something. The researcher did not make much of note-taking after the interviews as she was afraid of 'valuing' the segments of the co-researchers' stories according to her own biases. Therefore, the data collection process consisted primarily of tape-recording than note-taking.

Rarely did the need for a pause during an interview arise, except for the researcher to change recording tapes. The co-researchers did not refuse to answer any of the questions asked by the researcher. In fact, the co-researchers showed a great level of support for the study that after the interview, all of them asked whether 'what they said' could be any value to the study.

3.6   *Transcribing and Editing of Transcripts*

After each interview, the researcher asked the co-researchers whether they would like to read transcripts and preliminary analysis of data. Two of the co-researchers expressed interest in reading their interview transcripts. Transcripts were sent to those two co-researchers both by postal mail and electronic mail. Neither of the two co-researchers requested deletion or change in interview verbatim.

After each interview, the researcher asked the participants for permission to make additional contact if necessary. The co-researchers agreed to provide additional information on their oral accounts when clarification was required by the researcher. However, a follow-up interview was not necessary for the data analysis.

3.7   *Data Analysis*

Data analysis involved three main processes: textural description of the phenomena, structural description of the phenomena; and finally, synthesis of textural and structural descriptions to extract and document the essences of the phenomena/experiences (Giorgi & Giorgi, 2003; Mezquita, 1993; Smith & Osborn, 2004).

The textural description of the phenomena identified and discovered the common themes shared by the participants whose experiences differed from one another's by examining transcripts and written-responses from interviews. First, oral or written statements provided by the co-researchers were broken into and examined as sentences. The researcher refrained her biases in order to minimise (if not eliminate) judgement that might have been involved in the process. Sentences were not

evaluated assigned an equal level of significance and relevance to the study at this stage. Second, each sentence was clustered into common themes. Interpretation of the data was avoided by the researcher. Third, the researcher examined the common themes in order to identify patterns from different realities experienced by the individual co-researchers. The identified patterns were grouped, which established the master themes that represent essence of the co-researchers' experiences (Giorgi & Giorgi, 2003; Mezquita, 1993; Smith & Osborn, 2004)

The structural description explained underlying factors of the phenomena: why certain phenomena were experienced in a certain way; and, under what conditions they were experienced in such a way. With the textural dimensions of the phenomena, the researcher explored and built the structural essences of the phenomena. This was a stage where the researcher identified constituents and meanings that were indispensable to construct the certain phenomena—be it an object or a state of mind or affairs[23] (Giorgi & Giorgi, 2003; Mezquita, 1993; Smith & Osborn, 2004).

Finally, by synthesising textural and structural dimensions of the phenomena, the researcher articulated and documented the nature and meaning of phenomena experienced by the co-researchers; what and how the co-researchers experienced psychological difficulties and what affect(s) their experiences in the process? (Giorgi & Giorgi, 2003; Mezquita, 1993; Smith & Osborn, 2004)

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[23] Giorgi & Giorgi's (2003) analogy of 'cup' and 'cupness' provided easy explanation for seeking for the essence. For example, ceramic was not an essence of 'cupness'—or what made a cup a cup, because other materials could be used to make a cup. However, as a cup was an object that was devised to hold liquid, porous materials such as net would not make a cup. Therefore, nonporous materials—glass, plastic, metal, ceramic, wood, for example—would belong to the essence of a cup.

3.8   Phenomenology and the Researcher's Limitation

In order to acknowledge the existence of the researcher biases, the researcher made a list of her possible/potential pre-conceived ideas or positions regarding the topic of the study. The list consisted of premises constructed by the researcher's personal experiences as a counselling client, social policy student, and as a Korean-New Zealander: immigration experiences could be a factor that developed or triggered the co-researchers' psychological distress; the co-researchers may not be perfectly satisfied with their life as immigrants even when their immigration was voluntary; the co-researchers would not have much financial difficulties because most of Koreans migrated under the Investment Category; the co-researchers may not have much difficulty in English because many of them would have studies English in schools; it would have taken a long time before the co-researchers sought a professional help; the co-researchers would have suffered a prolonged and extreme psychological distress upon accessing a professional support system; the co-researchers would have dealt with their problems mostly by themselves; the co-researchers would have hesitated or felt reluctant before accessing a professional support system; somatic syndrome could have appeared before the co-researchers recognised their mental health issue(s); the co-researchers would have thought that seeking professional help was foreign and stigmatising; the co-researchers might feel at unease talking about their experiences with the researcher despite their voluntary participation; the co-researchers might try to screen their stories in order to save their face; the co-researchers could be sensitive about issues or questions dealt in the interview .

Philosophically and theoretically, a phenomenological study requires a researcher to be liberated from existing and potential biases; schemata, ideologies, or value

systems (Giorgi & Giorgi, 2003; Mezquita, 1993; Sarantakos, 1993). Only such liberation and emancipation will enable a researcher to document genuine experiences of participants without distorting their accounts of reality or phenomena—or to put it simply, what they experienced. In reality, such liberation or emancipation is not easily achieved by a researcher. A research process—including choice of topic, data collection, data analysis, and reported findings—are hardly immune from the researcher bias.

By making the list, the researcher could be clearly aware of her incapability to perfectly separate herself from her own indirect and direct experiences. However, the list was expected to guard the researcher against receiving and perceiving data shared by the co-researchers through her own lenses of schemata and perspectives. Phenomenological research method enabled a researcher to acknowledge the existing biases and therefore, to refrain from judgement during data collection and data analysis process: data should be collected in a pure and unscreened manner, without omission or distortion; during data analysis, every single statement of the participants should be valued equally.

Chapter 4   Finding

Analysis of the data resulted in six main themes that constituted the co-researchers'
experiences of psychological difficulties during their immigration process. Diverse
and yet identifiable real life experiences of the co-researchers are presented
according to the themes that represent and demonstrate the process of mental ill
health; from causations to recovery of mentally ill health. The findings are
displayed in a time-reverse manner. This is to intrigue the potential readers to
engage them in drawing inference as to what contributed to behaviour and general
states of the co-researchers.

This section begins with the co-researchers' reflections on their experiences.
Looking back the time, the co-researchers share how they could have prevented or
minimised their psychological difficulties. The next part acknowledges positive
aspects of support received from professional mental health support system. The
following part, part three, explores the implication of having regularity in life in
terms of mental health.

Professional mental health services were not the sole support to which the co-
researcher attributed their recovery and regained self-resilience from their weakened
mind state. However, the study found two distinct sources of non-professional
support for the single and married co-researchers. The fourth part discusses the
importance of social support in detecting problems and initiating recovery process.
The fifth part talks about how self-resilience can contribute to recognition of
problems and prompting healing process.

The sixth and final part contemplates human emotions; loneliness. This part investigates how the common emotional state should be related to understanding the mental health issues of immigrants.

Before presenting the findings in accordance to the six themes, a brief introduction of the co-researchers may enhance an understanding of their experiences.

4.1 Profile of Sample (in alphabetical order[24]. All were the "recent" immigrants (who had been in New Zealand less than ten years, but more than three years, at the time of data collection)

Bada: a single woman in her thirties. Lives with her parents who have immigrated to New Zealand before she did. Experienced depressive feelings while studying for Master's degree in Art Therapy and working full-time as a mental health carer at the same time.

Baram: a middle-aged ex-gambling addict. Moved to Auckland from other part of New Zealand after separated from wife. Drives a taxi and lives by himself.

Gureum: a single man in his thirties. Came to New Zealand by himself for an educational purpose. Experienced depressive feelings while studying for Master's degree in Social Work.

Haneul: a married woman with a baby in her thirties. Her husband has recently been recovered from a gambling addiction, which he had developed before the marriage during the time when he was running his own business by himself. Now he is a full-time employed engineer.

Namu: a single woman in her thirties. Came to New Zealand by herself.

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[24] Pseudonyms are used to protect identity of the co-researchers.

Experienced depressive feelings while studying for her Bachelor's degree in Psychology.

Pado: a married man in his thirties. Immigrated to New Zealand with his wife and two children. Ran own business for two years before he sold it in the process of recovering from the problem gambling. Plans to invest time in English acquisition and to work part-time.

4.2   *More Personal Than Situational: Self-Reflection on the Mentally Challenging Times*

Illnesses of 'mind' are no less common than those of the 'body'. As in the case of 'physical' (as opposed to 'mental') illnesses, causes, symptoms and severity of mental illnesses are simply not simple to be categorised and defined. Medical explanation may not always be available for mind/body disturbing symptoms that are causing the life quality of sufferers to deteriorate. There has been increasing acknowledgement of the 'stress effect' on human wellness—both on mind and body; the claim that a person's psychological and even physical conditions could directly be affected by stress level. In fact, such a claim has received official attention and acknowledgement from the Korean medical society. As a consequence, the medical society of Korea has even added two new types of death in their medical lexicon to address medically ambiguous causes of deaths. Now, a Korean can 'officially' die from stress and the death certificate would state the fatal cause as 'over-working' in the case of "Kwaro-sa" (extreme-fatigue death). Or, a Korean doctor can announce a death of a patient as "Dolyeon-sa" (sudden death), the cause of which is medically unidentified or at most, is identified as prolonged stress or distress.

As discussed in the literature review section, the immigration experiences were found to be a very challenging and an effort/resource-demanding process in many aspects (Berry, 1992; Brown, Abe-Kim, & Barrio, 2003; Constantine, Okazaki, & Utsey, 2004; Hurh WM. & Kim KC, 1990a; Hurh WM. & Kim KC, 1990c; Kim YS, 2002; Lee SSW, 2004; Lee, Crittenden & Yu, 1996; Noh & Avison, 1996; Rosenthal & Schreiner, 2000; Selvaraj, 2001; Vandervoort, Divers, & Madrid, 1999). It could require extra effort to re-established many of the aspects of life that are taken-for-granted, in a new environment. Studies defined an experience of immigration as a stressful event. Three of the co-researchers who suffered from psychological distresses that came to the surface as a form of gambling addiction were concerned that gambling was a serious problem among Korean-New Zealanders. A troubling number of Korean-New Zealanders were gambling addicts because, according to Pado's observation and analysis, they were "not happy with their (immigration) life, comparing with their good-old days before they migrated".

Each one of the co-researchers had their differences. Their demographic information varied regarding: sex, age, educational background, occupation, marital status, general living condition, wealth, and what have you. In addition to those nominal and measurable differences, each co-researcher also had distinctive personal characteristics that entailed elements that constitute each person as a unique human being.

Regardless of such differences, all of the co-researchers shared two common aspects: they all migrated to New Zealand from Korea; and they all experienced some forms of distressing moments. The experience of immigration involved more than legitimate visa and passport for the co-researchers. Moving to a different town within a country of one's origin could be challenging. Crossing an ocean to

're'construct a living system in another country would no doubt be even more demanding and challenging for many of migrants. The abundant quantity of social research on immigration—especially on adaptation and acculturation process—proved itself; that an immigration experience could induce a serious amount of personal stress and thereby, required attention from a societal and structural level.

For the co-researchers in this study, however, it was their 'attitude', rather than the situation itself, that could have been different in order for them to adapt to a new culture, society, and people in a more effective and efficient mode. The nature of an immigration process was "depend on oneself", Bada said. She believed that personal attitudes in perceiving and confronting external stress could make a difference between mental wellness from distress. All of the six co-researchers had their share of difficulties as they sought to acculturate into a new environment and to live a full life. Immigrants could face a variety of challenges that would need to be 'dealt with' in many cases. Such challenges could compose an 'endless' list of difficulties such as acquisition of the language spoken in the host country—a basic means of communication and interaction with indigenous people. As Bada confessed, there were difficulties she had to experience on a daily and regular basis and she was "still dealing with them everyday".

According to the co-researchers, it was their behavioural reactions to the situations they were placed in that could have made it 'easier' for them. Satisfaction with the status quo may not be exclusively determined by the physical environment per se. As Namu and Bada shared, personal capability to accept a given situation might benefit a positive outlook in life and therefore, increase the level of personal strength and subsequently, contribute to personal wellbeing. Namu, would like others, (in similarly distressing immigration situations) tell herself to "just be satisfied with the

current situation" and "not push yourself to make a big improvement or a noticeable change".

Bada also shared a similar sentiment, saying, "Had I not been that concerned about other people's judgement of me for the level of my English proficiency and reserved personality, had I not felt inferior and withdrawn, I would have been less stressed about relationships with other people."

Gureum also shared his share of regret about his 'then-reserved' attitudes when he was experiencing 'pathologic' loneliness. Gureum, who could not find a same age group of people to make friends with, told that if he had known what he knows now back then (when loneliness was the most difficult psychological obstacle living in a foreign land) he would have taken more active steps to meet people and become involved in social events. He resented that his strategy to overcome psychologically distressing moments were focused on personal hobbies which were mostly indoor and private activities—such as watching DVD, meditation or individual sports (such as jump-rope and weight training). As he gradually realised that such individual strategies were not much of a help in decreasing the difficulties he experienced as a sole migrant. At the time of the interview, he changed his strategies and participated in group activities and tried to 'put himself out there' more in order to meet people in a way to adapt to a new society while decreasing the level of his loneliness.

Choosing not to regret the past behaviours and resulting consequences was also adopted to enhance the present wellbeing. Baram's attitude towards his now-cured gambling addiction problem could be viewed as fatalistic at the first glance. As a religious man, Baram interpreted his past ordeal as a certain period of his life that was "destined to be" under the malignant spirit. To him, the gambling addiction and

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resulting financial and emotional distress was something that was inevitable and that must have been born with him. He believed that even if he had escaped the gambling addiction, he would have experienced something no less painful and distressing than the gambling addition that sank him to the abyss of despair. However, his fatalism should be distinguished from defeatism or negligence of one's life. It was more of the humble wisdom of Baram's that provided him with a positive strength to lead a productive life instead of being obsessed with a mistake committed in the past and his past misfortune.

The co-researchers' regret over their attitudes rather than the distressing situations they were in can be understood in the light of own definition of 'mental illnesses'.

"My underlying assumption is that under whatever circumstances, no one can deprive us of our freedom to perceive the situation from our own perspective. However, 'mental illness' can deprive one of the indestructible freedom to be happy and therefore, of one's capability to be happy".

Of course, knowing is one thing while acting on it is another. Otherwise, we would not need to excuse ourselves by saying the famous lay phrase, "do as I say, not do as I do".

However, the co-researchers emphasise that it was more about attitude rather than situation per se. Most of the co-researcher did not attribute their psychologically distressing experiences to the situations they were within. Instead, as Pado and Bada reckoned, "it depends on you, your determination and your attitude in dealing with situation." Most of the co-researchers resented their attitudes towards stressful situations they were facing, and as a matter of fact, Pado was the only one who

expressed resentment about his decision to migrate to New Zealand, in which life was more demanding and less fruitful compared to his life in Korea. The rest of the co-researchers believed that adopting different approaches towards more-than-satisfactory immigration situations would have changed the situations for better. Namu, who would blame her lack of linguistic confidence and reserved personality for not having been able to make many friends—and therefore, feeling lonely, isolated, and alienated—, shared the importance of being positive.

"If you know your strength and focus on positives, your happiness level increases".

4.3   *Taking Heals:*   *How Professional Help Helped Recovery*

Identifying the nature and cause of a certain phenomenon is a critical initiation towards understanding and improving the situation if needed. Diagnosis—whether in a personal or professional level—of psychological distress would involve acknowledging the existence of the problem as the first step to approach the issue. Such recognition of a problem may be followed by analysing and learning the underlying factors disturbing and resulting in the deterioration of one's mind and mental health. "Knowing what one's illness is about is the first step; knowing the name and cause of the illness", Bada claimed as she recalled how she dealt with her moments of psychological distress. In the process of diagnosis and cure, Bada would "definitely recommend" receiving proper professional support. Bada was not the only one who found involvement of mental health professionals—such as psychotherapist or counsellor—an effective way to recover and maintain a sound mind during the times of more-than-usual stresses. Such professional support was "essential" also for Pado to perceive and improve the severely damaged and almost destructive state of his life.

As a matter of fact, all the co-researchers agreed that they would utilise professional mental health system should they experience psychological difficulties again. "My husband and I were fortunate to have accessed and been supported by the counselling system", said Haneul as she attributed the improvement and stabilisation of their (her family including her husband and their baby) to the professional mental health support system. The co-researchers would also recommend reaching out for professional support for others who might be experiencing any kind of psychological difficulties.

Psychotherapists or counsellors may not be able to offer a practical help as for example, they cannot present us a magic wand that would solve all the worries and problems one experiences in life. Baram's sceptical attitude towards accessing professional mental health support upon learning the availability of such service was due to the 'impractical' nature of such support system. Baram did not contact the counsellor he was referred to by his friend and his boss. As the amount of his gambling debt accumulated, he always believed that he had a last resort to end all of his troubles; by killing himself. Instead of practicing a self-harm, though, Baram opted for an alternative solution to improve his life; he wanted to pay off his debt on a long-term instalment plan. His initial intention to contact the counsellor was solely to receive practical financial information on such instalment plans. To his dismay, he did not receive what he was hoping for. And yet, Baram also recommended seeing a counsellor should anyone experience any kinds and degrees of psychologically difficult moments.

Baram acknowledged the counsellor's contribution in his recovery process and said,

"The biggest help came from having someone to talk with. Your agony would ease away as you talk to somebody who is empathetic with you."

Baram had a satisfying experience with the counsellor although what counselling offered was not what he originally hoped to get. Baram was not the only co-researcher who appreciated having interactions with other people (in this context, the interlocutor was his counsellor) during his journey to recover psychological resilience and to restore his life. All of the other co-researchers experienced the similar cases of 'healing talks'. Talking about something that they had never shared with other people before was "good" (Namu and Pado) enough to make the co-researchers feel better. Namu also experienced the positive effect of talking as it dissolved the "feeling of frustration that I was struggling with." She remembers that "talking about the problem" already solved half of the problem.

In addition to the 'healing talk', counselling sessions empowered the co-researchers so that they could discover their strength and were reassured of their potential to overcome their hardships and distressing moments. Communication with an attentive interlocutor (a counsellor) with a focus on oneself resulted in therapeutic effect of 'knowing oneself'. Counselling session did not necessarily involve the counsellor offering 'realistic' advice on 'survival tactics' for the co-researchers. However, conversing with the counsellor or answering "questions the counsellor asked" activated the mind's process of discovering oneself. The self-discovery could be realising "new aspects of oneself" (Bada) or recollecting strength and positive aspects that the self possessed and exercised in the past (Pado and Namu).

In addition to 'healing talk' and 'self-discovery', counselling sessions also generated motivation for the co-researchers to 'take care of' themselves and 'be successful' in

regaining a sound state of mind. For the co-researchers, counselling sessions provided an opportunity to "think by and for" oneself. The process of such 'self-thought' brought back the memories of the successes and self-achievements the co-researchers accomplished in the past. Such thoughts and memories empowered the co-researchers to "carry positive thoughts into action" (Pado and Namu) and to restructure positivism and belief in oneself. Self-affirmation of positive strength in oneself encouraged the co-researchers to tackle the troubles they were experiencing.

On the whole, counselling sessions turned out to be a positive experience for the co-researchers. Interaction with empathetic persons (counsellors, in this case) comforted their weary or disturbed mind. Through counselling sessions, the co-researchers (re)discovered their strength and positive qualities. Talking with someone motivated the co-researchers to activate their once discouraged motivation to "lead a better life" (Pado) as they "did successfully in the past" (Namu).

The fact that the all the participants acknowledged 'talking' as an effective treatment may not be irrelevant to the fact that their difficulties stemmed from lacking a social network system and subsequently, feeling isolated, lonely, and alienated.

4.4   Weighty Regularity and Manoeuvring Daily Lives

Few would want to play a devil's advocate doubting the more than usual level of immigration stress. Being in a foreign land involves a wide range of stress factors that one may not need to experience should a person stay in his native country, such as adjusting to and fitting into a new set of a wide range of paradigms.

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The degree of adjustment difficulty would vary depending on the conditions and factors of immigration. Whatever the purpose, reason, socio-economic status, or demographic category an immigrant is applied to regarding the immigration, it would usually require more than visa and passport to secure one's place in a 'foreign' surrounding. At least, the co-researchers' immigration experiences involved more demanding tasks than relaxing moments. Pado described his family's immigration to New Zealand as a sacrifice of his wife and himself for the sake of their children. Pado's working schedule was very intense that he started working three hours after he arrived in a New Zealand airport. He did not have a single day off during the first two years in New Zealand, working hard as a sole provider for his family. Haneul's husband was suddenly left alone when his family had to leave New Zealand. Haneul's husband was alone in a foreign land, the country of which he could not speak fluently. Namu and Gureum, as singles, were physically alone in a foreign land, while struggling with English and the academic demands of school. Bada, though living with her parents, still had to struggle with her dual tasks as a full-time employee and a full-time student. In the working and studying scenes, Bada constantly had to "fight with" her loneliness with a self-destructive feeling of inferiority due to her imperfect English. Baram's separation from his wife left him no other choice than to leave the city where he had established a social network Korean people, and to move to a new city where he did not have anyone to share "real" conversation with.

One of the psychological defensive mechanisms opted for by humankind is known to be unconscious and yet voluntary 'amnesia'. We hear stories of amnesic people, who lost memories of certain parts of their life upon experiencing emotional shocks of an extreme degree. Although the co-researchers' migration experiences might not have been traumatic enough to generate an amnesic state, they seemed to have been

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distressed enough to opt for a voluntary and temporary 'blackout'. Gambling

provided Pado with a comfort zone where he could forget about everything else.

Like smoking, Pado compared, "gambling soothes you, just watching other people

can even be soothing." Gureum, who would drink pretending he was with his close

friends, said drinking was one of his coping strategies as it was a "(financially and

timely) affordable way to forget about the reality even for a moment." Namu opted

for sleeping because it was "better than being awake", as being awake implied

thinking and feeling the agonies of daily struggles. Namu also chose to stay in bed

longer because being awake and doing something required motivation, which she did

not seem to have at particular 'down' moments. Bada also shared the similar

experience with Namu. Bada found sleeping the most comforting activity when she

felt the door of her room seemed to be a threshold of her involvement of lively

movement.

Namu, Gureum, and Bada initiated constructing regular schedules for their daily

lives as they found themselves losing out on a healthy life and perceived-desirable

state of living. For Haneul's husband and Pado, re-organising their daily schedules

was a major part of their recovery strategy after recognising the seriousness of their

mental state and accessing professional help.

For three of our single co-researchers—Namu, Bada, and Gureum—, immigration

life did not involve much regularity because they did not have as many social

engagements as they had had in Korea. Less of social contact and involvement,

coupled with their main role as a student, permitted them flexibility of time

management. However, exemption from an outside-imposed regularity was not all a

welcome experience of freedom. Namu shared that being without regulation and

outside input was in fact a very difficult experience. "There was no feedback from

other people. No one to tell me study harder. No one to praise, encourage, or even criticise me", which Namu recalled "drove her crazy." Being without outside feedback could not only make one lonely, but could also deprive a person of a rhythmic and sound life style.

"Because I was on my own, I utilised different kinds of mechanisms to manage and regulate myself. Such as joining a gym membership in case I stopped working out regularly, or buying only the necessary amount of grocery to prevent binge-eating", Namu shared how she voluntarily put regulations into her life. For Namu, who never missed the group counselling session during the planned period of time, even attending the session each week was one of her strategies to build regularity into her life. By assigning herself with a mandatory schedule and regular duties to be accomplished, she felt better for her as she was adhering to her 'promise to herself'. Bada also injected regularity into her life and believed it was an effective strategy to maintain a healthy mental state. Bada would "make an occasion for which I must get up in the morning under whatever circumstances, such as going to a gym or taking some hobby classes." All three the co-researchers engaged themselves into regular working-out schemes in order to maintain otherwise drainable energy and motivation levels. They all also felt that physical exercise helped them to lessen their anxieties and stresses, enabling to refresh their mind and sustain both mental and physical health.

For Pado and Haneul's husband, having regular schedules in their daily life was adopted as one of the recovery strategies. Both Pado and Haneul emphasised the importance of having regular schedules and having mandatory daily tasks in order to rebuild and maintain a healthy life. Pado and Haneul's husband owned a private business, which availed them of a flow of cash and liberty, and sometimes, licence of

time management. During the recovery process from the gambling addiction, both Pado and Haneul's husband closed their business, opting for being hired and working for an employer. "Having a regular job involves arranging your daily life according to your working schedule. You cannot afford to think about something else (such as gambling)", reckoned Pado as he claimed that self-determined people with a regular job would hardly fall into addictive behavioural problems such as gambling. Haneul also attributed her husband's recovery from a problem gambling to having a regular and full-time job, working for other person. "Being hired by an employer means that now, the employer is in control of your schedule, not yourself. Working regular hours and earning regular amount of money on regular bases stabilised my husband's life. Now he is very busy that he does not even have time to think about other stuff (such as gambling)."

Such regularity, offering some rules of restrictions and boundaries in their life, contributed to solving the financial problems (generated by gambling debts), as well as regaining and maintaining healthy mind and relationships. Haneul's couple had been slowly and yet steadily coming out of the seemingly non-escapable hole of debts. The couple had been working hard and paying a certain sum of debt on regular bases, which had been satisfying to their creditors. As they did not have to be harassed by the creditors, Haneul's husband was relieved from 'debt stress' and focusing on his new job and family. Baram, although having suicidal thoughts, was still resilient enough to be determined.. He decided to pay off the debt and thought the only way to do so was working hard. He had been successfully paying off his debts, which was the fruit of his regular schedule involving hard work.

4.5   *The Role of Social Support in Recognising the Problem and Initiating Recovery*

For the married co-researchers—Pado and Haneul's husband—, the support from their spouse played a pivotal role in the recovery process from their gambling addiction. Pado appreciated his wife's support as the main contributing factor for rebuilding his life. "My wife was very considerate of me. She comforted me, which reduced my stress. The temptation to gamble was not that strong when you were not stressed," said Pado attributing his newly stabilised life to his wife. Pado believed that had it not been for his wife's support, he would not have got his life back on track. Both Pado and Haneul doubted the effectiveness of self-will and self-determination in acknowledging, accepting, and dealing with existing problems in a proper manner. "How could one do it (help oneself to recognise a psychological problem and engage in an appropriate recovery process), unless he/she is a god?" said Haneul as she emphasised the difficulty of regaining order in a disrupted life. Pado even claimed that help or advice should reach those who could and would support the persons with mental issues. "I don't think I would have anything to say to those who are having the problems", responded Paso when asked how his experience could help others in similar situation as he once was. "Instead, I would really like to talk to those who are close to him/her (the person with the problem), telling them that their support is the most important element in recovery".

In the couples' case, the spouses of the persons who were experiencing problems realised the seriousness of the situation. Pado and Haneul's husband were not completely blind to the gambling addiction. Pado and Haneul's husband were in fact distressed about their uncontrollable trips to irresistible casinos. They did not consider the issue as negligible. They were aware of complications of their

behavioural problem that were dismantling the life of their family and themselves—only, however, to be more stressed. Their gambling, which began as a way to ease their boredom and loneliness as an immigrant, was adding even more stress to their already-challenging life. Even worse, their distressed mind by the gambling addiction called for more gambling as an escape from the worries they had. Gambling was a temptation for them to forget about all the worries in their life. Gambling was a seductive solution to their financial problems, which was generated by gambling in the first place. "You know you want to and have to quit (gambling) even before you enter the room", Pado explained, "and as you leave the room, having lost all the money you had, there was an enormous regret having done it (gamble)." For Haneul's husband, gambling seemed to be the one and only option he could take to solve the financial (began as he started borrowing money to gamble) and social problems (as he grew apart from friends and families because he could not repay the gambling debt owed those close to him).

While their gambling-addict husbands were trapped into the gambling addiction and was only resorting to unreasonable and wrong choices of solutions, the wives of the gambling addicts took a determined step into the issue. Pado's wife and Haneul utilised their information sources—either through community notices or acquaintances—and learned that there was a support system out there. They acquired the contact information of relevant counselling facilities in which culture and friendly services were available. As they learned about the availability of Korean counsellors working in gambling-specialised support organisations, they offered the information to their struggling gambling-addict husbands. Gambling, which began as an innocent leisure activity to kill time for loneliness and boredom in a foreign country, became a hard habit to break. Eventually, the habit became a pathological behaviour that started destroying the quality and establishment.

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Gambling evolved to become a mental virus that dominated the mind and thinking ability of Pado and Haneul's husband. It consumed the life of gamblers and their families—well, almost until the wives of the gambling addicts started looking for a sensible route to sustain the wellbeing of themselves and their husbands as well as their marriages. .

Once determined to 'rescue' their husbands and save their life-establishment of marriage, the unyielding and far-reaching role of the wives of the gambling addicts was performed. In addition to persuading their husbands to seek professional help— in this case, problem gambling-specialised counselling—, Haneul and Pado's wife also participated in counselling session. Haneul and Pado's wife met with the gambling specialist counsellors in a way to learn effective ways to support their husbands throughout the recovery process. The counselling also provided them with ways to prevent relapse after making progress in the recovery. The counselling also provided moral support for the spouses of gambling addicts whose ordeal seemed to be no less harsh than that of the gambling husbands themselves. In fact, for Haneul's couple, it was the wife—Haneul—who had more counselling sessions than the husband, as the husband was not too willing to participate in counselling sessions. Haneul appreciated the amount of emotional support she had received from her counsellor. She could also maintain her stance as a supporter as her effort was greatly recognised and highly praised by the counsellor. The husband was less than satisfied and somewhat sceptical with the procedures of the counselling. And yet, spousal empowerment through counselling sessions helped enough for both Haneul and her husband to find peace and stability with their life. The case of two couples— Haneul and Pado—demonstrated how 'couple' therapy and spousal support could achieve an effective recovery.

A parallel examination of Haneul and Pado's accounts of the recovery process exhibit the core role played by the spouses of the addicts from the initiation to 'on-going' closure of the recovery process. Haneul obtained the contact details of an accessible counsellor (free-of-charge Korean-speaking counselling service) and persuaded her husband to attend counselling session. Pado's wife located the relevant information about Korean mental health supporting system and let Pado know there was a reasonable—both financially and valid—'help' out there. Haneul emphasised the importance of "giving a whole-hearted and full" support for a person suffering from mentally unsound state. Haneul doubted a person can be 'that' strong enough to make such a recovery by oneself, "unless he is an (almighty) god". Pado felt grateful for his wife's gestures in the recovery process and attributed his recovery to the support of his wife. Pado appreciated his wife's efforts to reduce his stress level in everyday life during the most challenging period of their marriage. "Less stress", Pado explained, meant "less temptation" to do gambling and subsequently, meant more time spent with his wife and children. Haneul was also aware of the 'stress factor' that could drive her husband away from the family and provoke an urge to gamble. Throughout the recovery process, Haneul made sure that her husband felt genuine support from her and reassured him that his wife was devotedly at his side.

Absence of the 'last resort' support from a family could cause a person's already-damaged mental stability and identity crisis to deteriorate. This is particularly so when the origin of such distress is social isolation; being alone in a foreign land. As the problem began with inappropriate choice of resolving the feeling of alienation, negligence from one's family would only narrow down the person's option to the origin of problem itself—in this context, problem gambling. As Haneul was aware, had she abandoned and given up on her husband, he would have had no place else to

go but casinos in order to comfort himself—at least temporarily with a long-lasting destructive impact. Eventually, both Pado and Haneul's husbands were back on track with their lives and the couples started restoring their almost shattered lives together.

However, Haneul had not fully terminated her own alert system, as she was aware and careful about the chance of her husband's relapse. "He has been there (gambling addiction) once and I suppose there always is a possibility of him falling into the same trap again". However, should the relapse occur, Haneul believed 'she' would be able to deal with the situation more wisely and promptly as she had also been there (supporting a spouse with the addictive hehaviour) due to her husband's behaviour. Haneul's caution may not all be invalid, as Pado confessed that he still has an urge to go to casinos and gamble after having been 'clean' for a whole year. It seemed that Pado had developed his own devices to maintain a healthy life, though. When he felt the compulsion (to gamble), he did not avoid or deny it. Instead, he would go to a casino but just to make coin changes for his bills in a way to test himself and be "reassured of his strength".

Recalling the experience of having a family member (in this case, her husband), Haneul regretted not having been able to notice the nature and seriousness of her husband's condition. While she claimed the indispensable role of a family, she also believed that families had a certain amount of responsibility and blame for an aggravated problem. Haneul resented the fact the neither her husband nor herself had not even given a thought that her husband was emotionally and seriously disturbed and moreover, was in fact 'ill'. "Had I known that he was in fact sick, I would have taken the necessary measures to tackle the issue promptly", said Haneul as she confessed that she did not know that her husband had had an "illness of

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heart"—or, psychological problem. Accordingly, she blamed her ignorance that her husband's illness was 'curable.' Not knowing the nature of the problem, the only trigger to seek outside support—such as talking to friends or consulting counsellors—was hitting rock bottom in terms of the financial and emotional state of their marriage.

A marital separation from his wife put Baram in the similar position as the single co-researchers—Gureum, Namu, and Bada. Fortunately, one of his friends played the part that involved recognising the seriousness of Baram's gambling behaviour and consequent financial problems. As in the case of Pado and Haneul's husband, gambling started as leisure activity for Baram to have some 'fun' with his friends. Eventually, the 'fun' had deformed into a self-destructive and repetitive pattern of finding (hoping to win 'big time' and pay off the debt cumulated through gambling) and losing the hope of life.

Finally, one of Baram's friends involved himself into Baram's seemingly problematic gambling behaviour. The friend started looking for ways to help Baram. Finally, the supervisor at the work place of Baram and his friend obtained the information about a gambling-addict support system that provided a culture and language sensitive service for Korean clients without the obligation to pay The contact details of the service were delivered to Baram and after some hesitation, he reached for a professional and systematic help.

Pado, Haneul, and Baram's meeting with counsellors did not happen until before their situations aggravated to the very worst and they realised that they had nowhere to turn to. Baram used up all of his savings and reached the overdraft limit with all of his credit cards. He even mortgaged his taxi to gamble. Baram, upon meeting a counsellor, thought the counsellor would have considered him as a "crazy man".

Pado used sales profit from his business to gamble. Money for living expenses was also spent on gambling. He explained that he was losing the sense of value of money and while he repeatedly told himself not to gamble, it was only after he lost every penny he had that he felt 'comfortable'. He even felt a sense of pleasure in losing money in gambling. He had been thinking he had a 'mental illness' when his wife suggested seeking a professional help. He recalled the observation he made upon other gamblers. He saw the "destruction and spiritual invalid" look on other gamblers' face. It suddenly occurred to him that he must have looked the same way—shabby and with a haggard face with red and desperate eyes—to people around him. He must not have been seen as a normal person with a sound mind. Haneul's husband also used sales profit from his business for gambling and was seriously indebted to acquaintances. The financial situation of Haneul's couple could have no more plummeted; Haneul had her wedding ring in pawn to pay deposit money for their rented home. The situation took a serious toll on their marriage when Haneul's husband took the money from the ring and lost all in gambling, instead of paying the deposit. Finally, Haneul's husband realised that he was in deep trouble—both financially and psychologically—, as Haneul recalled that moment, "he came home shivering and begged me to save his life".

"If someone does not go to hospital when ill, that's either because they don't know they are unwell or they don't know where a hospital is, perhaps because they are too tied up working hard. Likewise, if someone does not utilise professional help, I think that's because she/he doesn't know the availability of such service. Korean people might not have taken sufficient advantage of such support because they do not know help is available out there; and because they don't know they are unwell", Haneul observed as she emphasised the importance of community-based promotion and education for mental health related issues and available services.

The professional support system accessed by Pado and Haneul's couples and Baram was the service designed to meet specific needs of people from different linguistic and cultural backgrounds. The service was founded on the awareness that gambling addiction was one of the major concerns among the Korean community in New Zealand. The service provided Korean counsellors who shared the same linguistic and cultural background with Korean clients reaching the service. The service was also government subsidised and was operated based on providing free-of-charge counselling services and practical advice. As financial constraint is often one of the serious complications of problem gambling, free counselling services could have made it more accessible for those in need for such help. As financial problem could also deter a recovery from the addiction, legal and practical advice to restore financial stability in the clients' life also seems appropriate.

Other than the spouses and closest friend, the co-researchers did not or chose not to receive support from their families. "It will only worry them" was the concern or consideration behind keeping their difficulty a secret from their parents. In other cases, such a behavioural problem—in this case, gambling addiction—estranged the co-researchers from their siblings. Haneul avoided talking about her husband's issue to her brother, because her brother's harsh comments only added more stress to her already shattered mind that was reaching the limit of her tolerance and endurance. Haneul could not expect any kind of support —either as emotionally or financially— from her husband's families as they had 'given up on him.' Her husband's family expressed their resentment about their son and brother, telling Haneul not to 'even talk about it (anything related his gambling).' Baram's siblings also had turned their back on him.

Not receiving support—even emotional—from the immediate families, the co-researchers resented not having close friends to share their distress. Being a foreigner with a few close friends not only evoked mental ill-health. The state of being a migrant did not only make one vulnerable to loneliness. It also denies one the availability of intimate social support upon experiencing emotional hardship.

4.6   Self-Recognition of Problem and Self-Initiation for Recovery

Acknowledging the problem and learning the cause(s) of such problem will be a stepping stone to the road towards recovery and regaining a sound state of mind, as Bada suggested. Some of the research discussed in the literature review claim the 'Asian' characteristics as prohibiting factors for people from taking adequate approaches to deal with a distressed mind (Ahn T, Elizabeth & Tufts, 1980; Atkinson & Gim RH, 1989; Atkinson, Lowe, & Matthews, 1995; Bae SH et al., 2003; Bae SW & Kung WW, 2000; Chandras et al., 2000; Donnelly, 2001; Kim MY, 1994; Pang, 1990; Sue, 1994; Sue & Sue, 1987; Zane & Yeh, 2002). Reluctance to 'bother' close people—or to break the "group harmony"—and culturally encouraged self-resiliency were pointed out as the 'Asian' factors hindering timely and appropriate treatment (Constantine et al., 2004; Ho, Rasheed, & Rasheed, 2004; Taylor et al., 2004; Watari & Gatz, 2004). Unfamiliarity with mental illnesses, as opposed to physical illnesses, and the possible stigma attached to mental illnesses were also mentioned (Chandras et al., 2000; Donnelly, 2001; Kim MY, 1994; Shin SK, 2004; Shin SK. & Lukens, 2002; Tseng, 2004; Won et al., 2004; Yeh & Inose, 2002). Insufficient linguistic competency used in available mental health support services and unfamiliarity with 'Western' treatment processes might also increase the anxiety level in approaching help (summed by Akutsu, Tsuru, & Chu, 2004; Sue et al., 1991)..

The three co-researchers—Namu, Gureum, and Bada—broke the assumed pattern of the previous research ((for example, Kim YS, 2002; Lee SSW, 2004; Snowden & Cheung, 1990; Watari & Gatz, 2004; Yoo YG, 2002; Zane et al., 1994). Their self-awareness and self-diagnosis of their unusually irritated state of mind instigated seeking for support within and beyond their self-help. Bada was not "professionally diagnosed" and yet as she "observed her symptoms" and thought she was having "depression." She felt she was "missing a grip" on something that she struggled to hold on to in an effort to deal with her emotionally distressing situations. Gureum feared "losing a connection that associated" him with being the normal world. Gureum recognised a "glitch" in his body and mind "functioning." Gureum feared that he might develop a "mental illness" and was "on the verge of going mad," or might already have a mental illness without receiving proper treatment. Bada noticed changes in her behavioural patterns that she found unnatural for her. She described the unnatural state of being mentally 'ill' as "losing the capability of maintaining a balance between two opposite elements—such as yang and eum or light and darkness—, and consequently losing control". Namu also accounted for her psychologically vulnerable and distressed state as being "overly" or "unnaturally" reacting to inputs and feedbacks from other people.

Describing emotional, mental, or psychological experiences can be a complicated task and often, vocabulary in a language is not rich enough to deliver exactly what one feels. "I felt some unexplainable and yet irresistible change in myself", recalled Gureum. However, the co-researchers' shared vivid depictions of their emotional breakdown.

"I felt down and weary and was irritated by extreme stress. Then suddenly, I felt I missed a grip of something, something that I had been struggling to hold on to, and I felt I was sinking to the bottom. " (Bada)

"I was on the verge of nervous breakdown and I was afraid that I might cross a borderline (between normal and abnormal) and lose my link to normality. I felt if the state continued, the result would be something seriously wrong." (Gureum)

The three co-researchers experienced the similar psychological state which Bada described as the symptoms of depression. They share the same sentiment of 'not having the least amount of motivation and energy for whatsoever'. "What is the use of living at all when all is in vain," was what Gureum felt. They would stay home as they were irritated by meeting and talking to people. While their interactions with other people decreased, the amount of time spent in bed increased; their bed in their room would become their comfort zone. They overslept as they did not feel like doing anything or they did not wish to think about anything. It simply required the co-researchers of too much effort to get up and 'do something' or communicate with other people. Also increased was their food consumption, as Namu recalled she "could not even remember what I ate."

Being a sole immigrant—being single—may be a proof of their independence and strong self-will. All three of them were convinced that other people could not have noticed changes in their mood, as they were acting 'normal' when they were outside of their room and interacting with outer world. Bada's parents, although they were living in the same house, did not know the severity of their daughter's distress. Bada did not discuss her depressive mood with her parents because as was in the case with Haneul, she did not want to worry them. Being a single immigrant might have contributed to the vicious circle of the co-researchers' depressed mind. When they felt their status quo were too demanding or not in the way they wished it to be, the co-researchers felt depressive. The co-researchers would fall into the depressive state when they felt lonely and alienated in the new environment. When they felt

depressed, instead of acquainting themselves with other people and the outer world, they would reduce contact or interaction with other people. Getting outside and talking with other people seemed too stressful. Feelings of extreme loneliness, isolation, and alienation depressed the co-researchers, and their depressed state of mind served to disconnect them from outer world and people.

As they experienced depressive symptoms—reduced motivation and energy level, change in sleeping and eating pattern—they became conscious of their 'un-wellness' and need to seek help from outside. As in the case of illness-recognition, acquiring information for available and appropriate mental health services was proceeded by the co-researcher themselves. Once they realised that they were having difficulties maintaining a sound and healthy mental state, locating available professional help took neither extra time nor effort. Bada and Gureum had already known there was a counselling facility available for students in the schools they were studying at. Namu 'accidentally' saw an advertisement of the school counselling centre on the notice board of the school she was attending as a student.

As Haneul mentioned, locating health services could add more stress and anxiety to an already distressed mind and body, as it is usually when people are unwell when they look for such services. She was also concerned that locating such service facilities could be more of a challenge for immigrants as they might not be familiar with general social systems of the host country. For these concerns, the education background of the three co-researchers may worth mentioning. Schools, especially in the beginning of a school year, would try their best to promote students services offered for the students. However, not every student will be aware of the availability and contact details of provided services. The case may be similar with school notice boards. Not all students pay attention to every single advertisement or flies on the

boards. It would not be too outrageous to assume that people would tend to offer their attention more to receive information relevant to their life. In this respect, the co-researchers' study of major all concerned professional services for mental health issues: Bada was majoring in Art Therapy; Namu was studying psychology majors; Gureum's academic curricula included mental health counselling as he was majoring in Social Work. Accordingly, the field of psychiatry and psychology was not foreign to the co-researchers. Accordingly, it was a natural and reasonable choice for them upon realising their difficulties in sustaining mental health solely by means of their personal self-strategies.

There were multiple factors that encouraged and affected the co-researchers' decision to seek counselling help. First and most of all, they knew that they had problems that might require professional involvement. For the three co-researchers, getting counselling services involved advantages other than receiving professional help to learn more about and treat their symptoms. The available services were financially affordable, as the schools provided either free-of-charge or discounted counselling services to the students attending the schools. As they were all students struggling to make financial ends meet, the affordability of such services seems to have been an important to factor to their participation in counselling. Disappointed with the counsellor the school services assigned to him, Gureum sought a private counsellor—a New Zealander—at his own expense. Gureum did not—or rather, could not—make a second visit to the private service although he was quite satisfied with the session. He reckons he would have arranged for more sessions if he could have afforded to pay for them.

Participation in a counselling session was also a chance for the co-researchers to talk to and interact with someone, which was much needed at those moments. They felt

that their distress reached a level beyond their self-management. They felt and believed they "needed somebody to talk with." For Namu and Bada, the concept and process of counselling was closely related to their major part of their studies. They believed being in the position of a counselling client could be an educational opportunity for them to observe and practice a counselling process. They also expected being in counselling session would also provide them a chance to "practice English." English proficiency was both a stress and challenging factor for the co-researchers. Instead of seeking for a Korean-speaking counsellor, however, they chose to approach an English-speaking counsellor. They expected being in a counselling session would improve the level of their English competency. Not sharing the same cultural, ethnic, and national backgrounds with the counsellors was not a considerable issue for the co-researchers. None of them experienced communication breakdowns with their English-speaking counsellors. In fact, it was with a Chinese counsellor Gureum expressed his frustration as he felt that the communication blockage during counselling session. Gureum was not happy with the Chinese counsellor's command of English as she did not produce and receive English language perfectly. Gureum was also annoyed when the counsellor constantly offered him 'advice' as if she was an 'authority figure.' As mentioned earlier, Gureum found the counselling session with an English-native counsellor more effective and satisfying except for the fee for he could not afford for additional sessions. All in all, with all these positive and additional factors combined and considered, Bada thought to herself, "why not (seek counselling services)."

4.7   *Involuntary Solitude and Etiologic Loneliness*

Could loneliness be a pathological factor in a deteriorating quality of life and general health of migrants? Co-researchers identified and ranked the feeling of loneliness as

one of the most distressing factors as they struggled to fit in to a new environment. Among other stress factors, it was loneliness that topped them all for Gureum. Feelings of isolation and exclusion from other fellow colleagues at work and school was also the hardest part for Bada as she struggled to fit in.

The universal feeling of loneliness can be perceived from a new dimension within the context of immigration process. Gureum and Namu distinguished their experience of loneliness as the state of being without family or a partner. Namu described herself feeling like a "missing people".

"I didn't consider myself as sensitive to loneliness before I came to New Zealand. When in Korea, I would feel lonely because I didn't have a boy friend or because I was not living with my family. When I was in Korea, that's that. Here (New Zealand), however, a chance of meeting people is rare and I feel I miss 'people'"

Bada also recalled that there was "absolutely no chance" of making friends at school or at work. Gureum also differentiated his feeling of loneliness, 'I'm lonely because I don't have a girlfriend', pointing out that he could not make friends simply because he rarely had a chance to be acquainted with people in his age group. The single co-researchers (either not married or separated)—Gureum, Namu, Bada, and Baram—had to struggle with loneliness of being 'physically' away from close people. All of them agreed that there was little chance to meet people who they could talk with, letting alone making 'real' friends with whom they could share their thoughts and feelings. They all resented their relations limited to 'superficial' levels so that they did not or could not talk about what was 'really' going on—especially their difficulties dealing with loneliness and other stress factors as immigrants—in their daily lives without being defensive about other's perception.

The distance between loving someone and trying to love someone can be an alienating experience because the latter implies that 'it takes an effort to fancy you because in fact, I do not'. It is alienating because it either damage or exhaust the relationship or affect it n both ways. Such a sense of alienation can occur when people realise a distance between their ideal and current state. The co-researchers' wish to have friends was an alienating experience within a reality where finding a person who was 'friend-maybe' was a scarce opportunity. The circumstance in which there was no 'chance' of making friends was a stress factor. Trying to challenge the situation and make friends with others can be another stress factor. Trying without making a progress—that is, making new friends—can add another stress to the feelings of isolation and loneliness. Bada and Namu desperately wanted to tackle the situation and adapt themselves more into the 'main-stream' groups of people and culture. In the progress, however, they experienced frustration because trying to be included was different from being included. "I tried to be included but it did not work as it should or as I wishes. That was even more distressing", recalled Bada. Namu also shared a similar frustration of 'trying' to be included, "I would be delighted if I could have meaningful interactions and relations. I think I would be happy then, even if I failed in all my papers."

People are social animals, which implies that our existence is realised and sometimes reassured through communications and interactions with other people. Namu's analogy of her experience of loneliness reflects the otherwise-unappreciated role of

human interactions in one's 'ordinary' life. She compared her loneliness to the movie 'Memento' (2001, Newmarket Entertainment Group[25]).

"It's such a surreal and weird feeling that you are isolated, that there is no interlocutors to talk with in a continuum, in regular bases. Have you seen the movie, Memento? I felt like I was the man in that movie. Not that I couldn't remember things but in a sense that nothing in my life happened in sequences because I lack interactions with other people. No one to talk about my experiences yesterday, today, and tomorrow. I felt as if I lived here for thirty minutes and died, and lived there for thirty minutes and died. That kind of strange feeling captivated and scared me"

The researcher recalls experiencing a similar feeling of a total isolation. Being a new-comer in New Zealand sometimes made the researcher doubt her own existence in the world. The researcher would identify herself with the main character in the movie 'Sixth Sense (1999, Buena Vista Pictures)'[26]; that the researcher might in fact be dead and invisible to others, except that the researcher herself has not realised that she is dead.

While feeling of isolation can rather be a surreal psychological experience, it is indeed a very 'real' issue that could damage the status of being of the co-researchers. Gureum described the moment when loneliness "surge over" him as "excruciating" and "hitting the rock bottom". Gureum would be too depressed and have "absolutely

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[25] The movie features a man who tracks down his wife's murderer while suffering from short-term memory loss. In the process, he tattoos every piece of information he needs to remember in order not to 'forget'.

[26] The movie features a psychiatrist helping a troubled young boy who can see and talk to the dead. What the psychiatrist does not realise is that he is also dead and everybody in the movie, except him is aware of his no-longer earthly existence.

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no motivation whatsoever" to even try to overcome such an emotional state of mind. When depressed, Namu and Bada would find their bed to be a comfort zone, leading them to overstay in bed as they were waiting for time to pass by.

Pado and Namu regretted not having made sufficient effort and investment to acquire English proficiency upon the early stage of their settling process. Pado believed that had he been fluent in English, he would have met a greater variety of people and would not have fallen for gambling in the first place. Haneul's husband also started gambling when he suddenly became alone because his family had to leave New Zealand. Haneul explained that her husband's limited English limited his social boundaries and interactions, which resulted in isolation and loneliness. Linguistic and cultural capability (or incapability) of both Haneul's husband and Pado reduced their otherwise taken for granted interactions with people. According to Haneul, gambling was an offered option for her husband as the husband first put his foot with an invitation from an acquaintance to join him. The casino became a place for Haneul's husband to kill his lonely time and keep company with Korean-speaking people. Gureum, Namu, and Bada pointed out language as one of the major stress factors that hindered their adaptation to and involvement in a new environment.

For Gureum, Namu, and Bada, acquiring sufficient linguistic competency in the host language—in this case, English—meant more than developing the technical skill of verbal communication. Being a Korean immigrant in New Zealand placed them as a cultural, as well as linguistic, foreigner. A linguistic barrier involves more than merely not being able to produce and receive certain linguistic codes. Unfamiliarity with the culture of New Zealand increased an affective level and self-consciousness when they were interacting with New Zealanders. Perceived-limitation in linguistic capability reduces one's confidence in communication. Moreover, it seems that

linguistic incompetence could even impact the situational personality and relationship skill of the co-researchers.

"I would constantly worry about what they (colleagues) would think about my imperfect English. At work I was very self-conscious and anxious. As I felt inferior because of my English, a trivial mistake at work seemed a fatal one and I would worry about it all night. My linguistic incompetence reduced my self-perceived capability in other areas as well. My voice became smaller and I avoided people and became passive. Then I worried about what others thought about my passive and reserved personality. Every single moment was tense. " (Bada)

"I've found it difficult to communicate with my classmates. Perhaps because I worry about my English or because I worry about what they would think about me" (Namu).

Being a lone foreigner weakened the co-researchers' self-confidence. Namu recalled that it had been harder to be strong and independent as she was physically away from her social support groups including families and close friends in Korea. Being alone in a foreign land required extra effort for her to be active and confident in proceeding with her life. "We need to feel that we are capable of something", Namu explained her difficulty of being determined and strong without support from people, "when I need to plan something for my life in New Zealand, I tend to be negative about my capability to carry out certain tasks and consequently, I would just be discouraged from planning to do it"

Loneliness experienced by the co-researchers is perhaps a natural part of being in a foreign country. As natural as it may sound, not all immigrants may prepare themselves for alone-ness. Immigration entails a discontinuation of and physical

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disconnection from the native social support and social network system. For those

co-researchers who were singles—without a spouse—, immigration experience could

be more isolating and lonely as they did not have someone—such as a partner or

children, as Haneul and Pado did—to have even a casual conversation on a regular

and daily basis. Being in a state of total and physical alone-ness could deprive

someone of the taken-for-granted interactions with other people. Namu wished for

"even one person who would cheer me on or encourage me or even criticise me."

Gureum realised the positive strength a social network could offer after experiencing

'possibility' of togetherness with his colleagues. Soon after he got a job, he had a

casual social gathering with his office mates. As he was drinking in a relaxed mood,

he felt, "my heart was warming up and I belonged somewhere. Surrounded by the

atmosphere that was similar to being with my close friends in Korea, I learned that I

had been longing for sharing a certain cultural code with other people." For Gureum,

such a 'cultural code' did not have to come from people from the same linguistic and

cultural background. For him, it was being able to mix with and belong to situational

conversation and interaction that satisfied his longing for togetherness.

For the co-researchers who went through a gambling addiction, the first step into

gambling began when they became physically alone. Haneul's husband was

suddenly left alone in a foreign country when his family had to leave New Zealand.

He was a hard-working and self-reserved young man who suddenly had to deal with

aloneness in a country of which language he could not perform very well. It was this

time when one of his friend took him to a casino where he met and could spend time

with Korean-speaking people. Pado did not even know there was a gambling place

during the first two years of migration. It was when his wife was visiting Korea

when he felt boredom and spontaneously accompanied his acquaintances who were

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going to a casino. Baram did not gamble when living in another city with his family although the city had a casino. It was when Baram moved to Auckland after the separation that he followed his friend to a casino.

The co-researchers' reality as migrants failed to induce emotional contentment in the situations they were dealing with on an every-day basis. They were disconnected from social network that could have been taken for granted had they been in their country of origin. Being a migrant implies that one needs to establish a new set of social network and support system. A legal status and right to stay in New Zealand does not automatically involve linguistic and social competency and social belonging. Physical and geographical sense of loneliness can be escalated as migrants struggle with getting acquainted with new people in New Zealand. As the co-researchers experienced, the chance of meeting a diversity and number of people who were compatible for meaningful interactions was rarer in a foreign country.

Loneliness is not a simple and negligible emotional state that would eventually disappear. The co-researchers' less than satisfying status quo, which either included or was caused by loneliness, further bore complications of loneliness. Whether having depressive feelings or behavioural problem such as gambling addiction, being alone and sentiment of loneliness were an etiologic factor of mental ill-health of the co-researchers. In the process of experiencing psychologically challenging moments, the co-researchers withdrew more from social contacts or experienced deteriorated relationships with close people. Haneul's husband lost self-confidence and developed self-doubt about his capability to lead a productive life as a gambling addict. While his mind was obsessed with gambling, his social relations were damaged and he started avoiding people. As Haneul's husband had borrowed money from his families for gambling, his families lost trust in him and refused to provide

him with any kind of support. Haneul could expect neither emotional nor practical support from her husband's family while the couple was dealing with the difficulties.

Pado also remembered borrowing money from other people who were the few of his close friends in New Zealand. As Pado kept losing money in gambling and could not repay the money he was indebted, he fell apart from the social network he had established in New Zealand. Baram was also estranged from his siblings while being addicted to gambling. In the recovery process, Baram blocked himself from social gatherings upon breaking out of his gambling problems because he could not afford to enjoy the company of other people. Most alarmingly, Baram consistently had thoughts of suicide, repeating to himself that he "could simply commit a suicide if the situation does not improve." For the couples—Pado and Haneul's couples—, a problem of one spouse had a destructive affect on their marital life. Pado recalls having the first argument with his wife after ten years of marriage as the couple were struggling with Pado's uncontrollable gambling habit. As she learned about and tried to deal with her husband's gambling addiction, Haneul became depressive and resentful about her life. Haneul was suicidal when she was heavily pregnant with the first baby, and seriously considering a divorce.

Loneliness could trigger distress. Could a feeling of belonging have immunised people from experiencing certain emotional distress? Had they not been or felt alone, would they have not experienced psychological difficulties? Haneul referred to feeling of loneliness and deprivation of love as she understood the source of her husband's pathological aloneness and treatment option.

"I think that the 'illness of heart' is instigated by loneliness and can only be cured with genuine caring and love from others" (Haneul).

The above statement could imply that 'togetherness' can prevent ease stress level and prevent psychological distress. One of Gureum's strategies to ease loneliness involved an invisible company of friends. He would drink and pretend that he was "talking to him (imaginary friend), rambling more like, using languages I would use with my close friends in Korea. It actually worked and I felt better." Baram, who believed experiencing psychological difficulties was already written in one's fate, claimed the one and only way to recover was 'conversation'. Baram attributed his recovery from a gambling addiction to having decent conversations with a counsellor, resented not having friends to 'share' a conversation with. He found an emotional comfort by talking to and being listened to by a counsellor who "connected" with him and understood him.

"Whatever form of loneliness one may feel, he needs to be comforted with conversation. Only conversation can console your soul or sprit, not food, not medication."

Feeling of being loved can also be a preventive factor of psychological relapse. Haneul's husband, who developed a gambling problem while being single and alone without his immediate family, told Haneul that he might have "gone again (to a casino)" had it not been for Haneul and their baby. Haneul's husband believed that without his family, he would "feel too lonely" and would not be able to avoid the temptation to gamble.

Chapter 5:   Discussion

The present study aimed to document the lived experience of psychological difficulties of Korean-New Zealanders. The analysis of the co-researchers' accounts of their experiences offered an insight as to what triggered their distress and how they managed to restore their mental wellness. This section discusses how the co-researchers' experiences should be understood within the context of inevitable solitude during an immigration process. The importance of 'knowledge' is emphasised as both a preventive and cure-initiative factor upon experiencing psychological distress. The section also re-examines the much-promoted 'multi-culturalism' with an emphasis on the pitfall of generalisation, or lump-sum understanding of 'other' cultures.

5.1   Mental Health Issues of Korean-New Zealanders:
Social Animals Minus Social

Psychological difficulties the co-researchers experienced cannot be understood separately from the challenging nature of immigration. A successful adjustment and settlement do not seem to be achieved effortlessly, and the amount of research on those subjects partly proves it. Insufficient command of the language spoken in the adopted country can be more than a mere inconvenience in settling in a new environment. Limited linguistic capability lowered the self-esteem and induced negative self-perception in the co-researchers, resulting in little of social confidence. Subsequently, immigrants may opt to withdraw from society and people. In addition to linguistic barriers, settling would usually require securing material aspects of life; making a living. Securing the basic requirement of a 'living' might not be taken for granted. Many immigrants struggle to avail themselves of economic activities; as

either being hired or self-employed. Maslow (1943)'s model of "The Hierarchy of Needs"[27] displays a pyramid shaped ranking of human needs. In his book "Motivation and Personality" (1943), Maslow explained that a person's needs grew based on the lower need, and that people would need to be provided with the basic needs that would enable their survival in order to pursue the need at the next higher level. Only after the most basic needs such as security and food have been acquired, which were placed at the bottom section of the pyramid, would want to attain the needs on the higher and narrower sections of the pyramid; such as emotional and spiritual achievements in their search for wellbeing. Immigrants may find it hard to spare time and effort to building and maintaining new social relationships while struggling to meet the more 'essential' demands of living. Establishing financial stability or achieving career or education goals may leave immigrants little time to afford to build up social relationships.

As immigrants are often busying themselves to provide their families and themselves with shelters and food, their basic human identity as a social being may be on the shelf. Some people might seek for and be satisfied with a voluntary solitude. However, it is generally believed that the majority of human beings are in fact social animals. People establish and are assured of their identities with constant interactions with other people. Being situated in immigration process could often persuade or force migrants to ignore the need to be socially interactive. Perhaps migrants believe that socialising with the adopted society can wait until other seemingly more urgent and often material issues are resolved (Maslow may agree

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[27] The Hierarchy of Needs consisted of five elements of human needs. The very bottom of the pyramid—in other words, the most basic need—placed was "body needs." Once this need is satisfied, a person would want the next higher levels of needs in order of the importance of needs: "security", "social", "ego", and finally, "self-actualisation." (Maslow, 1943)

with the decision). Migrants may also be too reserved or even intimated to communicate with the host culture and people with limited linguistic and cultural competency. Should social belonging and connectedness be put on hold? Can they wait until immigrants achieve perceived-satisfaction with their seemingly more 'urgent' issues? Can immigrants successfully adjust to a new society and find their places when their invisible and yet pertinent human needs are unattended, either wittingly or not?

Social connectedness plays an important part in person's wellbeing. It is important that a person has a role, and therefore, feels he belongs in a society. Often the immigration process involves losing a social support network in the country of origin and building a new set of social support groups in a new environment. In order to belong to a society, a person may need skills — such as social and linguistic—and the opportunity to meet other people on a regular bases. The many challenges of the immigration process may limit such skill and opportunity for immigrants to be included in a society, while immigrants are in an intense need of social support in order to sustain wholesome life. The mental wellbeing of immigrants was documented as vulnerable in studies, featuring depressive symptoms, social anxiety, and extreme stress as the most common psychological difficulties immigrants faced. Social support can decrease the level of general mental distress of people. In this respect, loss or lack of social support could be an absence of a protective factor in sustaining the mental well-being of immigrants. Some of the collectivistic features of Korean people may add more difficulties as they struggle to establish their identity in a new environment. It was argued that collectivistic people tended to have more interdependent relationship patterns; identification and self-value were often determined through relationships. Collectivistic people also tended to be more concerned about other people's judgement. If so, the level of perceived isolation and

social anxiety may even be deeper among Korean immigrants. The level of life satisfaction could be hugely attributed to perceived social support and positive relationship experiences. The lack of such could generate feeling of isolation, exclusion, and loneliness. Not being associated with other people may be a detrimental factor to the mental health of immigrants. Kirmayer and Minas (2000) argued that health was a fundamental condition and asset for a full exercise of civil rights. In this respect, absence of belong-ness and connectedness may hinder effective settlement while disturbing mental wellbeing of Korean-New Zealanders.

5.2   *Mental Health Service Utilisation: Beyond Culture*

In general, some of the commonly known 'Korean culture' was found to be a prohibiting factors in recognising and seeking professional help upon experiencing mental health issues. Therefore, Korean immigrants' attitude and perception towards mental health issues were claimed to vary directly as the level of acculturation; recognition of problems, positive attitude, willingness to seek professional help and compliance with a psychiatric treatment process attributed to higher acculturation level. This study did not measure the acculturation level of the six co-researchers. However, the study found another possible factor that might explain mental health perception and the help-seeking pattern of people from different background. Three of the co-researchers—Namu, Gureum, and Bada—showed a similar attitude and help-seeking pattern upon experiencing psychological distress. They recognised and accepted that they had depressive symptoms by themselves. They did not need long time before locating and accessing professional help—professional counselling, in their cases. The background they share is their education. Their field of study involves psychology and psychiatry, which helped them to identify their problems and seek appropriate help. Hesitation or perceived-discrimination was not a concern

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for those three co-researchers as they experienced and resolved their psychological distress. The pressure they felt from their academic demand was a triggering factor for their mental struggle. However, they acknowledged that the fundamental problem of their distress was loneliness and a feeling of isolation; that they did not have friends to talk about their stress such as career and study.

While the above three co-researchers detected their problem (deprived of social relationships) by themselves and responded directly to the issue, the process of mental deterioration and help-seeking took a different path for the other co-researchers. Pado, Baram, and Haneul's husband's dissatisfaction with their life developed into a self-destructive behaviour and substance abuse such as gambling and excessive smoking. Unlike the co-researchers with an educational background that was related to their needs, professional help was researched and initiated by the social network in the case of Pado, Baram, and Haneul's husband. For married couples—Haneul and Pado—, it was the spouses (Haneul and Pado's wife) who acknowledged the destructive behaviour as a mental issue. It was the spouses who initiated seeking outside help, sought after supporting resources, and prompted accessing professional help. Spousal support played an essential part in the couples' case of recovery. For Baram, it was his close friend who acquired the information on a counselling facility for Baram to receive professional support. For the 'un-educated' co-researchers (that is, those without psychology or psychiatry background), it took a longer period of time before accessing professional help compared with the co-researchers with related educational background. However, perceived-discrimination or hesitation was not observed once they were informed of the availability of professional mental health services.

Previous studies found that common reasons for delayed or under-utilised service utilisation among Korean clients was due to the 'Korean culture's stigma associated with and different perceptions about mental 'ill' health, for instance. The help-seeking process of the co-researchers showed otherwise. The 'un-informed' co-researchers' professional help utilisation did not happen before their distress was disclosed in the form of addiction. However, 'cultural' aspects don't explain adequately the delay in seeking professional or outside help. While knowledge and information were contributing factors for the 'educated' co-researchers to understand and resolve their distress, lack of knowledge/information was a prohibiting factor for the others. Most of all, gambling was not perceived as a 'mental' problem—although not being a proud behaviour—, neither to the co-researchers nor to their close people. Accordingly and naturally, of the prospect of medical intervention did not occur to the three 'uninformed' co-researchers.

Previous studies also suggested that the norm of silence and self-containment could discourage Korean clients from complying with counselling sessions that mostly involved talking to the counsellor, a professional stranger. However, the co-researchers of this study all acknowledged interactions with their counsellors as a positive experience. All of the co-researchers in the study resented absence of 'friends to talk to' during their struggle for settlement. Some of the co-researchers did utilise self-help strategies such as involvement in physical activities. However, at the same time, they knew that such strategies were only an alternative to having close interlocutors on regular bases. Their self-help was not a result of Korean culture; self-discipline, will-power, or self-resilience. Rather, they were in serious need of friends and yet, their perceived-social support was far from being adequate. They analysed the fundamental cause of their psychologically challenging journey was not having close people around and feeling isolated and lonely. Interacting with

professionally trained counsellors seems to have provided the co-researchers with an oasis of communication. The co-researchers agreed—although the level of direct help was perceived in slightly different levels—that they found it a comforting experience being in counselling sessions and talking about themselves to a person (counsellor) who was ready to listen.

5.3   Multi-Culturalism: Oriental and Occidental

A rather popular dichotomy of cultures—Asian (or Eastern or Oriental) and Western—may require prudence when applied to understand and interpret people from different and 'other' cultures. Behavioural patterns of the co-researchers seem to have more to do with individual factors (such as marital status, educational background, kind of psychological problems) than pre-supposed cultural factors[28]. None of them showed any noticeable somatisation tendency while experiencing mental ill-health. Although some of the co-researchers analysed the cause of their distress as the breakdown of 'ki' or 'eum' and 'yang' imbalance, mental health professionals, rather than GP or Korean traditional doctors, were accessed for their unusually disturbed mind.

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[28] However, the limitations of the present study need to be noted. Due to the ethical concerns, the co-researchers' of the study were recruited among those with 'mild' cases of psychological distress. In addition, all of the co-researchers were either on recovery process or already recovered (they were capable of leading dependent, productive, and full life). It should also be considered that the problem gambling foundation (PGF) of New Zealand had Korean counsellors as gambling had been recognised as one of the most serious problems Korean-New Zealanders experienced. For the co-researchers with depressive symptoms, their field of study and English proficiency enabled them to seek 'Western' without much delay. Therefore, the study cannot account for Korean-New Zealanders with severer cases of mental illnesses and who lack information about service and linguistic ability.

The 'Asian' characteristic of somatisation of mental illnesses may benefit from a further contemplation than the 'strategically adopted bodily complaints' explanation. First, the somatisation may be a universal, rather than Asian-exclusive, phenomenon. For example, the depressive symptoms noted by DSM-III mostly involved bodily experience of discomfort such as weight/sleep disturbance and fatigue. Second, the linguistic aspects of Korea may also account for 'somatic' descriptions of psychological experiences. Idioms of distress may not be identical across cultures. Naming of and expression for certain illnesses could also differ among cultures (summed by Choi et al., 2002; Donnelly, 2001; Leong et al., 2003; Leong, 19886; Paniagua, 1998; Sue & Sue, 1987; summed by Yoo & Skovholt, 2001). As Kirmayer & Minas (2000) argued, the 'Asian' way of somatisation should be understood within the cultural and linguistic context—development of metaphoric expressions in its language. For example, 'black' is a Korean 'blue' that is often used to express gloominess—in fact, the colour 'blue' would more often be linked to something positive and energetic in Korean culture. As in other languages (Klienman & Good, 1985), the semantics of Korean language used body parts to develop metaphors or idioms that express emotional distress. Koreans may say "my chest is heavy as if I swallowed lead" or "something(one) drove a nail into my heart" to express upset and a hurt mind. They may say "my heart shrunk to the size of a bean" or "my knees are going numb" to express being shocked or scared. They may say "my liver is agitated" or "my liver is burnt" to express nervousness and uneasiness. One's liver would get "chilly" when one is fearful or scared. When a Korean says, "I have a headache", it could mean either: one; the person physically feels headache; or two; the person has to 'sort out' complicated matters and feels overwhelmed. A Korean may ask "does your stomach ache?", which implies "are you jealous?". Of course, it could literally refer to a physical stomach-ache. A Korean may express 'dizziness' with outburst of extremely frustrating situation (for

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instance, bankrupts, being cheated, and death of loved ones). Those idioms do not confuse Korean people because sentences are always used in context and are a part of the Korean culture. However, non-Koreans would not 'naturally' understand those idioms even used within a context. Lee KT (1983) claimed that the traditional Korean's view on medication also related psychological states to body organs: kidney with fear and liver with anger, for example. Ignorance or misunderstanding of those culture-specific idioms or choice of words may result in mis-, under-, or even over-diagnosis (Choi et al., 2002; Paniagua, 1998; Sue & Sue, 1987; Yoo & Skovholt, 2001).

For the commonly known 'collectivistic' people, it is interesting to note that none of the single co-researchers perceived their family members as persons they could rely on and talk to. Being deprived of friendship was much resented while the parents of the co-researchers were kept in the dark regarding difficulties the co-researchers experienced. In fact, for both single and married co-researchers, contrary to previous studies, parents were people were the last to hear of the difficulties their offspring was struggling with. Perhaps with regard to the 'in-group'(family and relatives) of the Korean culture, the emphasises is more on duty than kinship. In fact, Kashima et al (1995)'s study on collectivism and individualism found that Westerners showed a stronger orientation towards family and friends. 'Westerners'—the supposedly individualistic group of people—tended to have more close relationships with their families and friends than 'Asians'—supposedly people with a collectivistic nature. This is explained in that in-group membership in Asian familism has a stronger emphasis on 'duty' than kinship. Or, one could hypothesise that Korean people perceive socially developed relations (friends) as being part of the 'in-group'. The findings of the above study show that while the collectivism/individualism could be applied as a starting point or a rough framework to understand cultural differences

among people from various cultural and ethnic backgrounds, the dichotomy should not be overrated in a multi-cultural context (Oyserman, Coon, & Kemmelmeier, 2002). As Rhee, Uleman, & Lee (1996) argue, collectivism/individualism construal might not be the one and only dimension in measuring and perceiving cultural differences.

'Korean culture' would usually be understood along with 'oriental' and 'Asian' characteristics. However, nations and cultures in the Asian continent have gone through different processes of transition and at a different rate. Therefore, an attempt to understand or interpret the behaviour of Korean people based on traditional values under the umbrella term of 'Asia' may be misleading. The dichotomous description of 'Asian' compared to 'Western' should also be considered. Which cultures and countries belong to 'Western'? Where do regions in Eastern and Southern Europe, Africa, South America, and the Middle East belong? Would you presume people from France and from Italy to be culturally identical? Would you say a person from Austria and from Slovenia could probably communicate effectively if both of them possessed a reasonable command of English? They all are officially and geographically 'Europeans' or 'Westerners', and yet, one may need to think more than twice before deciding that an Italian would have a greater similarity with a German than with a Korean. 'Europeans' can be as different as a French baguette and an Italian Grissini. Likewise, although many Asian countries share borderlines or are geographical neighbours, their physical proximity to each other should not induce one to lump countries of distinct cultural and historical characteristics under the single category of 'Asia' or the concept of Orientalism.

A possible pitfall of perceiving or treating Asians (plural, implying there are different Asians from different ethnic, cultural, linguistic, and historical backgrounds) as

Asian (singular, implying people with 'black hair and eyes' are more or less the same) could not only be misguiding. It could also result in an ineffective and (though innocent) politically incorrect provision of services when permeated to an official and professional level. When Gureum, one of the co-researchers, first approached the school counselling centre, he was automatically assigned to a 'Chinese' counsellor. This 'culturally-sensitive' practice of the centre did not result in a pleasing counselling experience to Gureum. He was frustrated because he could not communicate productively with the counsellor as the counsellor was not a native speaker of English. He was annoyed by the way the counsellor kept giving him advice like 'stubborn traditional' people do. Later, he found that some of his Korean friends had also assigned been assigned to Chinese or Indian health professionals upon accessing health service providers. His friends shared similarly unsatisfying experiences with the Asian professionals regarding language and culture. Most of them even found it easier to communicate with native speakers of English than with 'Asians'. Most of them were of the younger generations while the professionals were often older. Gureum later sought a private counsellor who was a native New Zealander at his own financial expense. Gureum found the second counsellor more professional and capable, although he did not make a follow-up appointment as he could not afford it.

The most common error committed in the context of today's multi-culturalism is 'lumping' countries or cultures of different origins under the same category (Kirmayer & Minas, 2000)—for example, 'Asian'. This 'lumping', while providing convenience or assuming homogeneity of diversity with 'standardised' descriptions of the target population (Kirmayer & Minas, 2000), does in fact carry the of erroneous diagnosis and treatment when applied to real medical practice. The 'lumping' together also may disregard the context in which symptoms and

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behaviours related to certain illnesses were manifested. For example, the lump-sum word 'Asian' would not provide sufficient information to a clinical practitioner with multi-layered and complex experiences of people with different cultural, linguistic, and ethnic backgrounds. In a system where people from the Asian continent are categorised as a uniform group of 'Asians', individual differences and variances are ignored or neglected.

Generalisation within a group may also ignore the diversity of within-group members. As Chin (2002) argued, universal characteristics would only provide a rough idea of what 'average' person 'might' be like. Just in the case of 'lumping Asians', standardised assumption on people of the same ethnicity or nationality could also lead to unqualified and invalid assessment and treatment. Mix blue with red, and the result is purple. However, we cannot suppose that either blue or red is the same as purple. The 'presumably' shared values and thoughts of Asian cultures do not justify treating different cultures and nations in Asia as a monolithic group. 'Stereotyping' of Asians as a 'lump-sum' minority group would result in a deliberate ignorance of different contexts in which ill-health was experienced; language, culture, religion, history, acculturation level, migration experiences, values, and worldviews of many 'Asian' nations (Kagawa-Singer & Chung, 2002; Kim, BS, Yang, Atkinson, Wolfe, & Hong, 2001; Lee, SW, 2004; Solberg et al., 1994; Stuart, 2004; Sue, 1994; Sue & Sue, 1987; Yamashiro & Matsuoka, 1997). Moreover, Asian countries have histories of wars and conflicts (such as the Japanese colonisation of Korea, the Chinese invasion of Korea and the abduction of Korean people) (Paniagua, 1998). In this context, for example, assigning a Chinese counsellor to a Korean client could result in 'communication breakdown' and non-compliance with clinical sessions (Paniagua, 1998).

Galanti (2003) and Kim, MT (1995) both made a distinction between generalisation and stereotyping in providing health care for Korean-Americans. Generalisation referred to having knowledge of what the 'average' could be in a given population group. Individual variation and uniqueness would be acknowledged and noted as a more important source to understand a client. On the contrary, stereotyping was defined as a rigid and therefore often erroneous belief or mystification about a given ethnic group. A professional who stereotypes a person based on the basis of that person's ethnic-cultural background would see behaviour of that person within a given prescribed framework.

The genuine experiences and social dynamics of a given culture should be observed and weighed in approaching multi-culturalism (Miller, 2002). Confucianism and Buddhism cannot account for every aspect of Asian cultures, just as Christianity and pragmatism cannot is not the sole dominant mentality governing Western cultures. Kirmayer & Minas (2000) pointed out that multi-culturalists' openness towards 'other' cultures might result in unintended mistakes of perceiving traditional features of the 'other' culture as those of the present time's. The 'Orientalisation' of Asian cultures and nations by Western societies often shows this tendency. Traditional philosophic values--such as Confucianism, Buddhism, Taoism, or even shamanism— did exist in Korean society and some of the traditional values and practices are still appreciated and exercised[29]. Korea did and do have traditional way of medical practice. However, at the same time, as an old Korean proverb says, "even mountains and rivers change in a decade". Korean society passed historical eras of monarchy, agricultural, cold war, and so forth, just as Western society went though

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[29] Period of religious influence on Korea is as long as the history of Korea itself (which approximates five-thousand years). Confucianism was the official religion of Korea from the 14th to the 20th century, while Buddhism was the national religion before that.

Gothic, Renaissance, Victorian eras, just to name a few. Korean people should not be understood as clones of 'Asian' traditions and characteristics. Multi-cultural perspectives on psychology should entail openness and flexibility to capture yet-recognised or discovered features of other cultures (Miller, 2002). Considering immigration-specific experiences and acculturation process, one could expect more complex value system than collectivism among Korean-New Zealanders.

Changes in cultural patterns should also be considered as a sub-culture would be constantly influenced by a dominant culture (Kim, MT, 1995; Stuart, 2004). The lump-sum labelling and presumption of non-Western or non-mainstream population may lower the effectiveness of services: wrong definition of clients; negligence of complex nature of health/illnesses; and mis-application and mis-interpretation of psychological instruments (Stuart, 2004). Understanding other cultures is not a simple or straightforward process. Culture is such a complicated and multi-layered entity that is constantly interacting with other cultures. Culture does not possess a time-proof and value-free nature. It did not take more than several decades for Korea to transfer from an agriculture-based and family-oriented society to an industrialised and self-claimed 'individualised' society. Moreover, as Stuart (2004) explained, not every individual characteristic could be accounted for by cultural aspects. An individual cannot be represented by the average of the total group and it should not be neglected that within the same culture, individual socio-demographic variables vary (Chiu, 1996; Galanti, 2003). Individuals cannot and should not be fit into a ready-presupposed framework (in trying doing so, one would need to cut off or stretch the leg, as Procrustes (Greek mythology) —did and was later killed by Theseus)

5.4 Culture-Sensitive Service Promotion and Provision:
Knowing, a Pathway to Recovery

Bearing the pitfalls of 'lump-sum' multiculturalism, understanding and reflecting on Korean-New Zealanders' specific needs could benefit and lead to more effective service promotion and provision. It was argued that while behavioural acculturation would happen after a certain period of settlement—even within first generation of immigration—, value system remained and inherited to next generations (Kim, BSK, Atkinson, & Yang, 1999; Yamashiro & Matsuka, 2001; Watari & Gatz, 2004). This would indicate that even seemingly-highly acculturated immigrants with a perfect linguistic fluency in the dominant language might still be carrying the cultural values of their origins to a certain degree (Kim, BSK, Atkinson, & Yang, 1999). Previous studies found that compared with other ethnic groups, Korean immigrants were often slow in acculturation process (summed by Donnelly, 2001). If so, the social and cultural barriers Korean-New Zealanders encounter could be even more challenging, which may lead to the deterioration of mental wellness.

First, many of Korea-New Zealanders may not have sufficient social relationships. While the challenging nature of immigration process requires even stronger support from social network of friends and acquaintances, perceived-social support may be lacking for immigrants. If the social network was indeed more critical to 'interdependent' Korean people, absence or inadequacy of it might result in excruciating loneliness and social isolation. Second, as not every Korean immigrant possesses higher command of English, having Korean-speaking professionals would encourage relevant service utilisation. The co-researchers' satisfaction with and appreciation for the problem gambling supporting institution might not have been achieved without providing culture-sensitive services by the Korean counsellors.

Third, as Haneul emphasised, 'knowing' could make a big and positive difference among Korean immigrants. Some might not approach professional help for commonly noted 'cultural' reasons. However, others may not be represented in professional mental health services simply because they do not realise that they are unwell and they can improve their situation with professional intervention.

A person could react differently to the influenza virus each time she/he feels the effects of the virus. When the second time comes around, people will have learnt how to prevent infection or minimise unpleasant symptoms. Even the first-timer may deal with the flue if one is aware of the symptoms and treatment options. Personal experience can be compared to history. The negative process of a personal experience does not need to be repeated as long as a person learns from the previous experience either by direct or indirect exposure. Psycho-education or mental health promotion could benefit not only the present sufferers and their close people. Namu, Bada, and Gureum wasted little time accessing counselling because they had been informed of the psychological and psychiatric aspects of 'un-wellness'. As such, people would respond more efficiently and effectively upon experiencing psychological problems if they had been informed and educated before. In addition, as in the case of Haneul, Pado, and Baram, 'knowledgeable' friends and families could provide much stronger and productive support for their distressed loved ones.

Previous studies found that Korean people tend to assess primary health care services—such as GP, physician, or traditional doctors— or religious leaders upon experiencing mental illnesses. This study does not confirm the previous findings. However, a linkage between the primary health care sector and mental health services might benefit Korean immigrants (Bae SW & Kung WW, 2000; Hong, GK, 1988; Kim, MY et al., 2002; Purnell & Kim, 2003; Shin, J.K., 2002). In addition, it

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would be meaningful to examine and analyse service-utilisation data from such medical service facilities. This could provide useful information on causes, manifestation, help-seeking pattern choices, and people's perceptions of mental illnesses that are Korean culture-specific (Yamashiro & Matsuoka, 2001).

Chapter 6: Conclusion

Among various and different levels of challenges immigrants may encounter, the study finds the feeling of loneliness—including isolation from other people and society—as a notable and yet least anticipated challenge an immigrant may have to experience. As argued in the previous studies discussed in the literature review section, the present study also finds knowledge about potential mental exhaustion and distress as an important element in maintaining sound mind as well as general health. The study concludes with some suggestions for 'preparedness' during an immigration process—both for immigrants and the host country.

6.1   Legal Aliens

No one would choose a friendless existence on condition of having all of the other things in the world   *- Aristotle*

Few would play devil's advocate to controvert the potential negative complications of an immigration experience. Everyday routines that used to be taken for granted in their country of origin can become a scene for a battle survival. Regardless of how well prepared and organised immigrants are as they plan their major geographic transfer, not all of them will have been anticipating the social and cultural challenges immigration may entail. In addition to the usual phenomenon of social downgrading (possibly due to insufficient qualification or linguistic ability for employment and proper income), immigrants will have to encounter a duel that cannot be disregarded; a duel against nobody else than themselves as they will continuously have to struggle with inner as well as outer conflicts in the process of adjusting to and settling down in a foreign environment.

Struggling with everyday affairs is not a burden that is exclusive to immigrants. As the Buddhist philosophy perceives, the fundamental nature of human life may be suffering, which also applies to people living in the country of their origin. However, what makes the life of immigrants more challenging and isolating than that of the native people will be the matter of social relationships; a social network that can function as a support system when one is in need, be it practical or emotional. Perhaps the psychologically draining or even destructive experiences the co-researchers confronted could be attributed more to their lack of perceived-social support (for example, friends) than the visible difficulties they encountered (such as demand from work and study).

Korea has been a mono cultural and ethnic country for more than five thousands years. It was only after the second world war that 'Westerners' started coming to Korea and it has only been about fifty years since Korean society and people were exposed to cultures other than Korean (except for mutual influence with China, the country sharing a borderline with the northern part of the Korean Peninsula). Before WWII, Korea took a great pride in the fact that Korean people are the descendants of the same ancestor, and therefore sharing the same lineage. The great pride of being member of the racially and culturally homogenous nation remains in the modern day Korean people and society. Perhaps this could partly explain why Korean immigrants find it even harder to interact and 'mix with' people from other ethnicities and cultures. Even in educational institutions, be it secondary or tertiary, it might not be too hard to observe Korean students flock together with other Korean students.

The study found that one of the major factors in the degenerating health mental status of Korean-New Zealanders was feeling of alienation, isolation, and loneliness. Satisfying social relationships can function as a buffering factor that can empower and help a person deal with problems inevitable during an immigration process. On the contrary, lack of social relationships and the subsequent feeling of alienation and loneliness would make encountering and overcoming challenges of daily struggles of immigrants. However, loneliness is a personal and emotional state a society may feel impuissant in coming up with support or resolution. And yet, society can provide alternative protection at an institutional level in order to diminish the degree of immigration stress. As discussed in the literature review section, stressors commonly associated with immigration—such as linguistic barriers, perceived racism and discrimination, and loss of social support—can be reduced with provision of immigrant settlement services and support system (Berry, 1992; Bae SW & Brekke, 2002; Kim YS, 2002; Noh S. et al., 1992a; Yoo YG, 2002). It would also help for mental health service providers and professionals to understand that feeling of alienation and isolation from people and society could be a major cause for mental health issues of Korean-New Zealanders. Understanding the cultural-historical consequence of Korean people's clannish demureness could also explain the psychological struggle Korean-New Zealanders may be experiencing in the course of acculturation and assimilation into their adopted country, in this case, Aotearoa/New Zealand.

6.2 Empowering Knowledge

The only thing more expensive than education is ignorance -Benjamin Franklin

The study observed two different patterns in help-seeking behaviours. Those who had background knowledge about mental health issues and had resources to locate relevant service facilities did not waste much time before seeking professional help. On the other hand, those who did not perceive their (or their spouse's) behavioural symptoms as 'pathological' had to 'hit the bottom' before they sought the availability of help and learned about their problems and possible solutions. The finding suggests the importance of mental health promotion that raises awareness and delivers logical (as apposed to mystical) and practical information. As Haneul, one of the co-researchers, mentioned, Korean people will seek medical help once they are aware that they are unwell. Perhaps the commonly known Korean (or Asian) phenomenon of under-utilisation has more to do with people (im)properly acknowledging their issues and the issues of the people close to them.

The study found that a social network can indeed play a crucial role in making personal problems noticeable. A social network was also found to play an important part in preventing, supporting, and minimising the symptoms of psychologically distressed persons as a spouse or friend. Therefore, including social network as an empowerment system when promoting mental health may be effective. All in all, community-based and the culture-specific promotion of mental health support system may increase mental health awareness among Korean-New Zealanders. Such educative promotion may not only help Korean-New Zealanders who are currently facing mental health issues themselves but also their loved ones. Such promotion may even prevent the onset of the common mental health issues of Korean-New Zealanders such as substance abuse, behavioural disorder, and gambling addiction. Such promotion can also increase awareness about possible impact of immigration process on emotional and mental health.

None of the co-researchers of this study expressed concern about discrimination and although the study has limitation of not involving Korean-New Zealanders with more severe cases of mental health problems. However, mental health promotion and education could minimise or eliminate potential stigma and misconceptions about mental illnesses. This would encourage prompt and appropriate help-seeking if needed. It could also decrease or diminish illogical judgement and unfair treatment on people experiencing mental health issues.

Quite contrary to the previous findings, the co-researchers' participation in mainstream counselling did not involve the issue of 'face' or self-containment. Upon experiencing psychological distress and resulting mental health issues, none of the co-researchers were concerned with discrimination or stigma upon accessing mental health professionals. Although there might have been some hesitation before being determined to actively participate in treatment process (in the case of this study, counselling), all of the co-researchers agreed on the positive impact of 'healing talk'. Contrary to previous studies, the co-researchers in the study found counselling to be a positive experience because they had someone to talk about their personal issues and experiences. None of the co-researchers resisted sharing their personal thoughts and feelings with a counsellor. Perhaps the counsellor was perceived as an alternative to 'friends to interact with', which the co-researchers felt was needed.

Once Socrates told Alcibiades, "know yourself", as inscribed in the temple at Delphi. The famous two-word phrase entails the meaning of 'discovering oneself' in order to 'take care of oneself' and to 'be successful'. The co-researchers all shared that during the course of counselling—which mostly consisted of talking about themselves to counsellors—they had come to learn what their problem was and rethink who they were. The co-researchers perceived 'talking with counsellors' as a

door to learn about themselves and subsequently, finding the problems and solutions within themselves and by themselves. Participation in counselling sessions was seen as the effort required for the co-researchers to 'become wise' or 'know oneself' in order to 'take care of' their conditions and regain strength to lead a productive life.

6.3   *It Takes Both Sides: Suggestions and Recommendations*

The two pillars of political correctness are: wilful ignorance; and a steadfast refusal to face the truth   *- George McDonald*

As discussed above, an immigration experience entails complicated challenges to Korean-New Zealanders for reasons that have been commonly identified. English, one of the two official languages spoken in New Zealand is merely a foreign, not second, language in Korea. It would be no easier for a Korean immigrant to receive and produce the English language than for a New Zealander (who, for example, learned French in secondary school) to freely use French language. While immigration inevitably involves a loss of established social network in the country of origin, building and maintaining a new social support group may not come about easily. Language will certainly discourage Korean-New Zealanders from being absorbed in the main stream New Zealand society. The historical and cultural 'exclusiveness' is unlikely be contribute to becoming acquainted with people other than Koreans and becoming a 'real' citizen of New Zealand society.

As the co-researchers shared in the interviews, adapting oneself to an adopted country demands extra effort to obtain and maintain even those elements of life once taken for granted. Although immigration to a foreign country is a prudent decision made after thorough contemplation and preparation, surviving in a foreign

environment may present a continuum of unexpected hurdles to overcome. Feelings of loneliness and isolation from a society, and associated complications such as a feeling of depression and gambling addiction, were a major factor in causing the degeneration of the co-researchers' mental health. Perhaps even more so, because there was no warning of such difficulties nor had they been anticipated. Such factors may trigger both external and internal alienation of Korea-New Zealanders from the New Zealand society.

Facilitating effective settlement and adjustment of Korean-New Zealanders would require acknowledgement of undeniable issues by the settlers—Korean-New Zealanders—and the New Zealand government. For Korean-New Zealanders and potential Korean immigrants to New Zealand, comprehensive research would be essential before considering and deciding on immigration. New Zealand can indeed be one of the few 'last natural paradises' of the globe. And yet, the paradise requires more than romantic expectation and idealisation for its dwellers to enjoy what the country could offer. A paradise may only be a harsh reality and a cruel scene of isolation for strangers and outsiders. There cannot be too much preparation and anticipation for barriers and difficulties immigration would likely to entail.

As a society that identifies itself as multi-cultural, social structure of New Zealand often reflects propagated multi-culturalism. Accordingly, promoting and providing mental health services in New Zealand also proclaims multi-culturalism and cultural-responsiveness. In this respect, the study wishes to congratulate the Problem Gambling Foundation (PGF) for their culture and language sensitive services. The three co-researchers with gambling addiction issues might have not regained stable mentality had it not been for such services. The PGF, being aware of the seriousness of Korean-New Zealanders' gambling issues, provides Korean-speaking female and

male counsellors. Such achievement of the PGF supports the suggestions for benefit of providing culture-sensitive services.

As observed from the cases of the PGF and previous studies as discussed in the literature review, suggestions to enhance the health (especially mental) status of Korean-New Zealanders may include providing interpreters, recruitment of more Asian health professionals, and development of culture-sensitive services (APHPR, 2003). Generally, mental health professionals' cultural competence would reduce the possibility of misdiagnosis. Cultural knowledge and sensitivity would also attract the under-represented ethnic group in mental health services (Choi et al., 2002; Lee & Darnell, 2002). This is especially so as the study found that the under-utilisation of relevant mental health services might have more to do with insufficient knowledge about mental health issues and availability of professional support system, rather than the stigma associated with mental health issues.

From the governmental and policy level, acknowledgement of culture-specific issues and the needs of immigrants from various backgrounds may be a stepping stone to building a truly multi-cultural and stable New Zealand society. The government, especially the sectors involved in immigration and related issues perhaps such as the Ministry of Labour, the Ministry of Health, and the Ministry of Social Development, would need to increase the availability of culture- and language- friendly services. The introduction of culture-sensitivity and culture--responsiveness in promoting and providing mental health services is not merely a politically correct gesture. In the practical sense, understanding the individual background is essential in the practice of psychiatry (Chiu, 1996; Kirmayer & Minas, 2000; Lee & Darnell, 2002). At a societal level, the successful settlement and adjustment of immigrants in New Zealand would also enhance social cohesion and economic development.

Representation of people from diverse cultural and ethnic background does not automatically establish a multi-cultural society. In this age of globalisation, each nation would have their own causes and agendas to be globalised, for example, encouraging immigration and revising immigration policy in the context of this study. In the interest of such nations that are in the process of promoting and becoming a multi-cultural society, constructing a practical and realistic immigration policy is essential before either raising or lowering the national border. Such a policy would need to include theoretically thorough and realistically comprehensive consideration and planning that could facilitate and aid successful immigration. Immigration is a personal decision and it certainly requires each individual immigrant to be well prepared and have boundless levels of determination. After all, success or failure in immigration and subsequent mental wellbeing would largely be attributed to individual responsibility and capability. However, at the same time, such individual immigrants behave and function within the context of society and a policy framework.

In order for (potential) immigrants to exercise full citizenship, accurate and sufficient information about the adopted society could is a prerequisite resource. The immigration policy of a nation, therefore, should involve providing a realistic picture of immigration and the potentially adoptive nation. Immigration policy would also need to include a settlement support system that is approachable and useful, and most of all, promoted with regard to its availability. Perhaps New Zealand could benefit from an original, more stable, and Aotearoa-specifically designed immigration policy that suits New Zealand as well as new settlers in the land of long white cloud.

The study was inspired by the researcher's limited assumption on the correlation between mental illness experience and culture. Researching previous literature gave rise to a certain degree of presupposition from the researcher. It was tempting to hypothesise that certain characteristics of Korean-New Zealanders' mental health experiences would be at least partly be attributed to Korean culture. However, the findings defied, rather than confirmed such presuppositions and presumptions. The study does not wish to suggest that culture is irrelevant in understanding behavioural patterns of people from different ethnic and cultural origins. However, it does wish to claim that culture should not be understood in a mathematical login of average and union. Various sets of cultures may have intersection, and yet, difference of sets of cultures should also be counted in order to define each set of cultures.

In addition, observation and analysis of other cultures should consider the possible existence of complement. Pre-existing framework may not be complete to capture and understand unique and diverse aspects of different cultures.

Understanding and appreciating other cultures beyond the mathematical logic could also be applied to perceive diverse cultures and ethnicities that belong to the same geographic unit of the world. The continent classified as 'Asia' is not composed of a mono-ethnic group. Multiple numbers of cultures and nations constitute the Asian continent with their unique heritages and belief systems. There are an increasing number of Asian people in the self-claimed and self –promoted multicultural society of New Zealand. There may be certain ethnic and cultural groups with relatively more immigration population, and accordingly, their culture and language may seem to represent something or someone 'Asian'. However, Korean people and culture are not the average of various people and cultures originally coming from different parts of the Asian continent. Also, despite seemingly being exotic and even neo-romantic,

Asian cultures and people are probably more than crouching tigers and hidden dragons[30].

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[30] "Crouching tiger, hidden dragon" is the title of internationally recognised film (Sony Pictures, 2000) directed by a renowned director Ang Lee who is originally from Taiwan. While the movie acclaimed fame from both critics and lay audience with featuring near-mystique martial art and love, the four-word title phrase originally has an even more 'Asian' implication; that the true heroes live in seclusion.

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Massey University
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Experiences of psychological difficulties and help-seeking patterns of Korean New Zealanders: socio-cultural factors underlying psychologically distressing experiences and utilisation of relevant services.

INFORMATION SHEET

Researcher(s) Introduction

This study is conducted by Sueyon Kim for her Master's thesis research and supervised by Dr. Grant Duncan and Dr. Christa Fouché. The project seeks to generate data about the experiences of psychological difficulties and help-seeking patterns of Korean-New Zealanders. The researcher will employ a qualitative research methodology to collect data from your voluntary participation. Any information shared by you as a participant will only be used for the purposes of research. In addition, the study will safeguard the identity of the participants as well as ensure your anonymity.

If you have any concerns or questions about the research, please contact the researcher or the supervisors:

Sueyon Kim
E-mail: subcelsius@hotmail.com
Mobile Phone: 021 063 5991

Dr. Grant Duncan
E-mail: L.G.Duncan@massey.ac.nz
Phone: 09 414 0800 (ext. 9086)

Dr. Christa Fouché

E-mail: CB.Fouche@massey.ac.nz

Phone: 09 414 0800 (ext. 9082)

Participant Recruitment

An advertisement will be used to recruit five voluntary Korean participants who have experiences of psychological difficulties and relevant service utilization, and who are willing to participate in semi-structured interviews. Any actual costs (e.g. transportation) generated by participating in the interview will be compensated by the researcher. The interview involves the interviewer (the researcher herself) and each of participants in your choice of time and place. For an ethical concern, those of you who are aged under 18 or over 65 will not be included. However, the researcher is aware of the possibility that due to the sensitive and personal nature of the research questions, you as a participant may experience some psychological discomfort. Should this happen, the research provides personal support services through Massey University Student Health and Counselling Centre and Mr. Simon Seung-wook Lee (see below for contact details). The Massey University Health and Counselling Centre provides free counseling services to Massey students. The researcher will also provide a list and contact details of relevant services where you can reach for emotional support.

Massey University Student Health and Counselling Centre

Location: Bld. 100 Oteha Rohe campus, Gate 5, Massey University (Auckland)

Phone Number: 09 414 0800 (ext. 9783)

Web: http://students.massey.ac.nz

Simon Seung-wook Lee

Clinical supervisor / Psychotherapist / Researcher

Accommodation for Mental Health Society Inc.

1 Nile, Milford, Auckland

Phone Number: 09 41006004 / 021 1855961

Project Procedures

The data collected during the research procedures will only be used for academic purposes and only be accessed by the researcher and the supervisors during and after the research. After the completion of the research, the tapes will be destroyed by the researcher. The transcripts of the tapes will be stored securely and managed by the supervisors over a five year period and will be destroyed at the end of the storage period. Upon the completion of the research, a summary of the completed research report will be sent to each of the participants by the researcher. The following forms will be made available if requested to preserve confidentiality of identity: Consent Form and Information Sheet (see Participant's Rights section)

Participant Involvement

Interviewing will be conducted at the place and in the time of the participant's preference/choice. Only the researcher herself, as an interviewer, and yourself as an interviewee will participate in the interview, and you will not need or asked to meet and talk with other participants of this study. Each interview will last no longer than 120 minutes and you can ask for a break at any time during the interview session. The interview will consist of general questions asking about your experiences of mental difficulties. After the interview, the researcher may contact you only when it is necessary to do so (for example, to clarify or to help understand your answers properly). With your permission to do so, the researcher may arrange a follow-up interview for clear and deeper understanding of your accounts. This follow-up interview can be arranged through your preference/choice (such as telephone interview, written interview, face-to-face interview). Again, a follow-up interview will take place only with your permission and agreement to do so, and the whole purpose of a follow-up interview is to deliver and present your genuine account of the experiences with the utmost precision and the least distortion.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
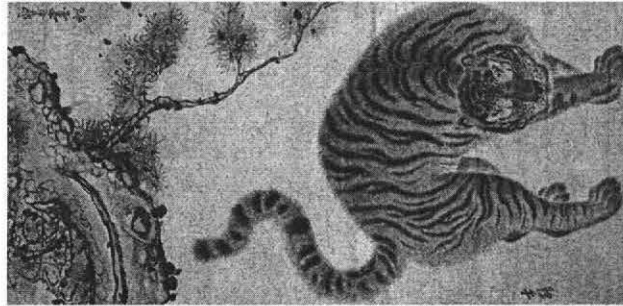- decline to answer any particular question;
- withdraw from the study at any time within one week after the interview (or the follow-up interview);
- ask any questions about the study at any time during participation;
- be given access to a summary of the project findings when it is concluded.
- to ask for the audio tape to be turned off at any time during the interview.

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB Application 05/007. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz

Appendix B: Participant Recruitment Advertisement

Time to Let A Voice Be Heard to Enhance Mental Health of Korean-New Zealanders and to Facilitate Culturally Appropriate Mental Health Services
(Massey University Ethics Committee Approval Number: 05/007)

I study Social Policy at Massey University as a Master's student and my name is Sueyon Kim.

Sueyon Kim
Contact : (Email) subcelsius@hotmail.com
          (Landline) 479 - 8335
          (Mobile) 021 – 063 – 5991

ASIANS
Sometimes, I feel Western understanding of Asian Culture tends to be dominated by particular Asian cultures and information on that particular cultures. What would you think? We Koreans have our own culture, lifestyle, and value system that are distinct from other Asian cultures.

OUR VOICE
If we only submit ourselves to perceived 'barriers' and 'differences', perhaps we are blocking opportunities for other cultures to know and understand us.

Sharing your own experience can build a foundation to let New Zealanders know our values and understand our circumstances. Furthermore, your voice may contribute in developing Korean-friendly service systems.

Please Take Your Step to Let Our Voice Heard.

Your account as a Korean living in New Zealand and of psychologically distressing experience does add values to research and policy development.

If you want to take your part in, please do not hesitate to contact me.

5 YEARS
Western research says it usually takes 5 years for Asian people to seek appropriate services regarding mental health issues. How long did it take you to seek professional help? How long did it take me, I reckon.

BARRIERS
Western research attributes the 5 years to various factors such as culture, language, values, information about relevant services, and so on. What do you think? Would you say their paradigms could explain you, or us?
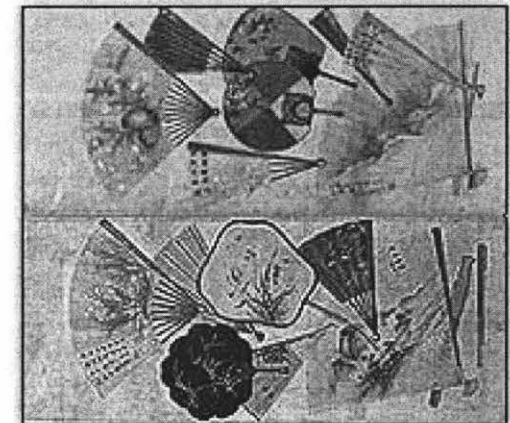
Appendix C: Interview Schedule

The questions are broad-based and include recordings of the following variables: the participants' feelings, thoughts, and experiences of psychological difficulties; social issues including the impact of their illnesses on family, work, social relations, and migration.

The study employs semi-structure interviewing as a social research technique to explore real-life experiences of Korean New Zealanders with experiences of emotional/psychological difficulties/distress/discomfort. Semi-structured interviewing will also facilitate authentic and substantive descriptions of lived-experiences of the participants. The researcher will conduct interviews with five individual participants.

The interview schedule consists of six main areas of inquiry following a "thematic approach" suggested by Quinn-Patton (1998): questions to do with experiences or behaviour; knowledge questions; questions to do with feelings; opinion questions; sensory questions, and background/demographic questions.

1. Tell me about yourself (family, work, migration experience, duration and kinds of psychological difficulties).
2. If I were having any psychological difficulties, what experiences would you share with me to help me? For example, how did you first notice your emotional distress? What actions did you take to cope with such difficulties?
3. What is your opinion about people who have experienced psychological difficulties? What advice would you give to Korean people who are going through psychological difficulties?
4. How would you define 'psychological distress/difficulties/discomfort' or what would be examples of such? What do you think 'psychological distress/difficulties/discomfort' are; such as causes, symptoms, treatments, so forth?
5. How does your experience (of psychological difficulties) affect your state of mind?
6. What do other people (Korean or others) say about your difficulties? How did they (Korean or others) respond when they learned that you were experiencing psychological distress?

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PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being audio taped.

I understand I have the right to acquire the original tapes.

I wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**
....

Full Name - printed
....

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Korean New Zealanders: socio-cultural factors underlying psychologically distressing experiences and utilisation of relevant services.

AUTHORITY FOR THE RELEASE OF TAPE TRANSCRIPTS

This form will be held for a period of five (5) years

I confirm that I have had the right to read and amend the transcript of the interview/s conducted with me.

I agree that the (edited) transcript and extracts from this may be used by the researcher, *Sueyon Kim,* in reports and publications arising from the research.

Signature: **Date:**

....

Full Name - printed

....