Qualitative Study of Depression Literacy Among Korean American Parents of Adolescents

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ABSTRACT
Lack of depression literacy is associated with low help-seeking behaviors for mental health care in adolescents. As parents generally determine adolescents’ health care, ensuring parents can recognize depressive symptoms is crucial. The current study explored depression literacy among Korean American parents of adolescents ages 12 to 19 using a qualitative descriptive design. Semantic content analysis was performed using data from three focus group interviews conducted in 2015 with Korean American parents (10 mothers, four fathers) of adolescents. Participants lacked knowledge about the biological causes and medicinal treatment of depression. Most believed that depression cannot be fully treated, relapses occur easily, and medication is taken indefinitely. Gender influenced perceptions of symptoms. Parents often overlooked children’s depressive symptoms until schools alerted them. Nursing interventions should educate parents about the biological causes of depression, strategies for addressing adolescents’ symptoms, community-based professional resources, and success stories about depression treatment. [Journal of Psychosocial Nursing and Mental Health Services, 56(1), 48-56.]

Managing adolescent depression creates family, economic, and social burdens (Beyondblue, 2011; Healthy People 2020, 2012). Early detection and treatment of adolescent depression are essential to lessening these burdens. As parents are the main decision makers for their children’s mental health care services, it is crucial that parents recognize symptoms of depression (Beyondblue, 2011; Boughton & Lumley, 2011).

Depression literacy, the ability to recognize depression and make decisions about its treatment (Rickwood, Deane, Wilson, & Ciarrochi, 2005), is correlated with positive attitudes toward use of mental health care services (Jorm, 2000; Rickwood et al., 2005), whereas lack of depression literacy is correlated to low help-seeking behav-
Parental depression literacy may be a moderating factor between depression and adolescent use of mental health care services (Rickwood et al., 2005). Marcell and Halpern-Felsher (2007) found that adolescents perceived family members to be as helpful as mental health care services. Another study reported that family interest in and communication about health issues could increase the use of health care services (Marcell, Ford, Pleck, & Sonenstein, 2007). It is important for parents to recognize adolescents’ depressive symptoms as early as possible and to hold positive attitudes toward use of mental health care services, as these factors can significantly impact help-seeking behaviors.

Korean American individuals are underrepresented in initiation and maintenance of treatment for depression (Juo, Kim, Shankar, & Han, 2004; Sin, Jordan, & Park, 2011). Despite the importance of parental depression literacy, few studies have explored this concept in Korean American parents, and there has been little research focused on measuring depression literacy in this population. The lack of measures targeting depression literacy may have limited researchers’ ability to capture factors specifically related to depression. The current study explored Korean American parents’ depression literacy with the goal of contributing to knowledge about the relationships between depression literacy and help-seeking behaviors in this population. An additional goal was to provide evidence for developing a depression literacy scale for Korean American parents.

METHOD

Study Design

Jorm’s (2000) mental health literacy model, modified to focus on depression, was the theoretical framework that guided the current qualitative descriptive study. In Jorm’s (2000) view, symptom management can be initiated by symptom recognition by the affected individual or others close to him or her. Thus, the perspectives of the individual’s family are important for such recognition (Jorm, 2000). The framework guided the current authors’ focus on knowledge and beliefs about depression among Korean American parents of adolescents.

Qualitative data were obtained using focus group interviews, as the group dynamic and contributions of each participant’s experience promote collective generation of new ideas and deeper discussions (Smithson, 2000). Such interviews may increase participants’ mutual empathy and encourage sharing of what might be considered culturally private family matters. Content analysis provided a detailed description of the dataset (Braun & Clarke, 2006). Specifically, a semantic content analysis approach was applied to identify themes within the explicit meanings of the data; nothing beyond what participants explicitly expressed was considered in the analysis (Braun & Clarke, 2006).

Sample and Setting

Data were collected from a purposeful sample of 14 Korean American parents living in the Chicago area who had adolescents ages 12 to 19. Ten mothers and four fathers who met the following inclusion criteria were recruited: (a) Korean American parents; (b) had adolescents ages 12 to 19 living with them; and (c) could fluently speak, read, and write Korean. Focus group participants were recruited from the Korean American Community Services (KACS) center and from one Korean church. Along with many parent members, KACS and the church had parenting education programs for those interested in learning about their adolescents’ emotions and behaviors. The first author (Y.M.J.) attended these programs to introduce the study and recruit participants meeting the inclusion criteria.

Ethical Considerations

The study was reviewed and approved by a university Institutional Review Board (IRB). A waiver of signed informed consent was granted because the IRB determined that the study posed minimal risk to participants and that their written signatures would pose a potential risk to their confidentiality. A study information sheet distributed to all participants before the interviews informed them of the study’s purpose, procedures, and minimal risks; this information was orally explained by the first author, and oral informed consent was obtained from participants before the interviews began.

Data Collection/Procedure

Three focus group interviews were conducted in September and October 2015. The first author developed the interview guide based on Jorm’s (2000) model (Table 1) and moderated two interviews in a private room at KACS and one in a private room in the Korean church. The first and third interviews (designated M1 and M3) included only mothers, and the second interview (designated F2) included only fathers, thus maximizing the homogeneity of gender characteristics within the groups; this approach also allowed married couples to express potentially differing viewpoints. The interviews were audiorecorded, and field notes were handwritten by the first author. Participants provided demographic information: age, gender, year of immigration, level of education, and children’s ages.

Data Analysis

To maximize study trustworthiness and confirm the neutrality of the analysis process, the first author worked under the supervision of a senior member of the research team and an external researcher (Sargeant, 2012; Zhang & Wildemuth, 2016). The focus group interviews were transcribed, and each sentence was numbered. To compile data for each focus group, the first author used a Microsoft Excel® data spreadsheet containing three columns: participants’ ID#, coding, and responses (Krueger, 2002).

Semantic content analysis was used to interpret thematic meanings of sen-
**TABLE 1**

**FOCUS GROUP INTRODUCTION AND QUESTIONS**

| Introduction | Welcome: “Thank you for agreeing to participate in our focus group. I really appreciate your participation.”  
Introduction: “I am Yoo Mi Jeong, a PhD student at the University of Illinois at Chicago. I will be moderating the focus group.”  
Purpose of the study: “I am interested in learning about your knowledge and beliefs about depression and how to deal with it. I would like to hear your opinions about these matters specifically.”  
Ground rules: “To facilitate the focus group interview, there are a few rules to be kept in mind by each member. First, there are no right or wrong answers for questions, so I hope that you will be honest and talk freely about your own ideas and opinions. Second, everything that we talk about will be kept in this room to make all members feel comfortable in sharing information. Third, I hope that each of you will speak and be respectful to the other members. Finally, I will be audio-recording and taking notes on your responses during the interview, but all data will be kept anonymous and secure to protect your confidentiality. All focus group participants are reminded to keep what is said in the interview confidential and are asked to use a “nickname” rather than your own name. Although we ask everyone in the group to respect everyone else’s privacy and not to identify anyone in the group or repeat what is said during the group discussion, confidentiality cannot be guaranteed.”  
“Let’s begin with everyone introducing themselves using only their nicknames. Please tell each other what you are currently doing, the length of time that you have lived in the United States, and how old your adolescent child is.” |
| Engagement questions | Questionnaires for demographic data, a blank sheet of paper, and pencils will be distributed to participants by the researcher.  
“Before the interview, I would like to ask you to answer the questions and circle the answer that fits your situation. These questions are to aid in the analysis of the data and this information will not be linked to your name nor will it be shared with anyone else.”  
The researcher will gather the completed questionnaires for demographic data.  
“Now, I am interested in learning about your knowledge and beliefs regarding depression and how to deal with it. First of all, I would like to hear your thoughts about depression. What kinds of words come to your mind when you think about depression?”  
After participants list words related to depression, “Please circle the words that describe depression well. Why do you think so? Let’s talk about your opinions.” |
| Exploration questions/ statements | “Do you think you can distinguish between depressed and non-depressed children?”  
“I would like to hear your opinion about the cause of depression.”  
“I would like to hear your opinion/beliefs about help-seeking behaviors for depression.”  
“I would like to hear about your attitude toward any mental health care services.”  
“I would like to hear your opinion about seeking help for depression.” |
| Exit questions | “Finally, is there anything else you would like to talk about regarding your knowledge or beliefs about depression? Or is there anything you want to tell me that I didn’t ask about your depression knowledge or beliefs?” |
| Closing | “Thank you again for participating in this focus group. Your passion and your responses will help us determine how to enhance knowledge about depression and about how children with depression can be helped in a timely manner. Thank you.”  
A $10 coffee shop gift card will be given to each participant.
tences and phrases and explore attributes associated with depression and its management (Mallery, 1991; Zhang & Wildemuth, 2016). First, the transcripts were read and re-read independently by the first author and external researcher, both having experience in qualitative research, to identify content themes, sub-themes, and codes (Zhang & Wildemuth, 2016). Second, a coding framework was established to identify themes and sub-themes, and each transcript sentence was identified and categorized according to the associated theme (Zhang & Wildemuth, 2016). Throughout this process, notes were recorded on the initial analysis as well as labels for codes. Next, one research team member (Y.M.J.) and the external researcher met to organize codes into categories and reach consensus on the themes. An audit trail was maintained and regularly reviewed throughout the analysis process. The second interview with Korean American mothers (M3) produced similar themes to the first interview (M1), resulting in near-saturation of data. Because it was not possible to recruit enough fathers to conduct a second interview, full data saturation was not achieved.

RESULTS
All 14 focus group participants were Korean American parents living with their adolescent children in the greater Chicago area. Table 2 shows demographic characteristics. Residence in the United States ranged from 1 to 31 years (mean = 13.1 years, SD = 7.8 years), and the age range of participants was 38 to 56 years (mean age = 44.7 years, SD = 4.5 years). All participants had at least a high school education; most also had a bachelor’s degree.

During data analysis, five principal themes were identified. Each is discussed below.

Theme 1: Definition of Depression
All three focus groups defined depressive symptoms in emotional terms, most frequently using the word “sadness.” Groups M1 and M3, consisting of mothers only (n = 10), used the words “sad,” “no energy,” “loneliness,” and “depression” to describe depression. Group F2, comprising fathers only, also defined depression as “sadness” or “loneliness.” In addition, fathers defined depression as “having no interest,” “having fear,” “related to death,” and “feeling confusion.” Mothers and fathers further defined depression as presented in the sample quotes below.

M1: Depression, it means feel down, cry a lot, no energy, nervous, alcohol or substance dependency, social distress…

M3: No energy, if children do not have motivation to do something, they will be pessimistic for everything and will look like being sad…

F2: I think suicide is the most relevant to depression. Not treated or cured, self-destroy, suicide.

F2: Lower self-esteem, if self-esteem is strong, it would not matter whether they have friends or hang out with them. If the situation is bad, if they are confident or have high self-esteem, they will get through hard things.

F2: I think loneliness. Isolated by friends. Loneliness, not happy family.

Only M1 participants related depression to physical symptoms, such as lack of sleep or appetite, in addition to emotional distress, as shown by one mother who stated, “I am not sure whether my daughter has depression or not, but she seemed like she could not sleep well or not eat well when she was stressed out from school things (issues with her friends).…”

Theme 2: Misconceptions About the Causes and Treatment of Depression
Parents generally lacked knowledge about biological causes of depression and held faulty beliefs about causes of depression. Parents’ comments reflected their apparent belief that the main causes of adolescent’s depression were parenting style and family issues. One M1 mother said, “When mothers or fathers nag them a lot, children get stressed and depressed.” Another M1 mother added, “Parents expecting and forcing their children to be better than other kids cause children to become depressed.” Mothers and fathers valued open communication; an M1 mother stated that lack of communication between parents and children might cause children to feel depressed. One father said that he wanted to communicate with his daughter but did not know how to begin a conversation with her.

Linked to their belief that depression is caused by parenting style, parents expressed a strong sense of guilt over their children’s depressive symptoms. As one M1 mother was saying that she and her husband were too strict with their daughter, she began crying and said that her daughter’s symptoms were their fault. This M1 quotation il-

### Table 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>(Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>44.7 (4.5)</td>
<td>(38 to 56)</td>
</tr>
<tr>
<td>Years living in the United States</td>
<td>13.1 (7.8)</td>
<td>(1 to 31)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10 (71.4)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4 (28.6)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>3 (21.4)</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>10 (71.4)</td>
<td></td>
</tr>
<tr>
<td>Master’s degree or higher</td>
<td>1 (7.1)</td>
<td></td>
</tr>
</tbody>
</table>
illustrates the belief that depression is caused by style of parenting:

My daughter went to the library with her father…. He nagged her for half an hour on the way home because she was not in a good mood. Because he kept nagging her, my daughter said that she wanted to jump out of the car to kill herself. [crying] Even at that time, I did not try to understand my daughter’s emotions. [crying] I feel bad that my daughter’s symptoms have gotten worse since this happened.

Beliefs about causes were associated with beliefs about treatments. Because parents believed that parenting style is a cause of depression, they said that changing parenting style is one main way to treat depression. For example, an M1 mother stated, “A mother should be strong and change her parenting style to more directly show her children that she cares about them.” However, five mothers believed that depression is a disease that occurs when children have little willpower and receive too much financial support from their parents. One mother stated that depression is a “bourgeois disease” because too much support from parents spoils their children and makes them mentally weak. In addition, mothers stated that children’s emotional and financial dependence on parents weakens their sense of independence to the point that they were prone to mental disorders. These beliefs led parents to believe that depression should be treated by changing their parenting style, not by counseling therapy or antidepressant agents.

Other beliefs about the causes of depression included biological factors, such as physical illness and weak nervous systems, stress, family history or genetic factors, peer group issues, personality factors (e.g., a tendency toward perfectionism), environmental factors, and low self-confidence or self-esteem. However, all participants lacked knowledge about the biological causes of depression; thus, they were skeptical that medication would be effective in treating the condition. Parents’ comments revealed false notions about antidepressant medication (e.g., the medication is addictive) that led them to believe that such medication should be discontinued as soon as possible. One M1 mother stated:

...Mothers stated that children’s emotional and financial dependence on parents weakened their sense of independence to the point that they were prone to mental disorders.

There is one son from parents who are both professors, once he started taking medication since a child, he could not stop taking medication, and his symptoms were not better ever since then. He is taking medication so far…. I saw him recently, but he still looks awkward. He should’ve not started taking medication.

Theme 3: Views of Depressive Symptoms

Korean American parents accurately described changes in their children’s habits, behaviors, and emotions that are consistent with symptoms of depression (American Psychological Association, 2015). For example, parents commented on lack of pleasure, sad moods that lasted a long time, low energy, oversleeping or insomnia, overeating or lack of appetite, lack of interest in doing things previously enjoyed, somatization, and suicidal ideation. However, some mothers did not notice somatization in their children. One M1 mother related this experience:

My daughter was sick a lot in 5th grade. Quite often she had a stomachache each month. She also kept saying that she was sick in 6th grade, so she went to a specialist. She was diagnosed as having IBS [irritable bowel syndrome], which is related to stress. But I did not take her to a psychiatrist or mental health clinic because it was too expensive.

Another M1 mother replied to this statement:

A stomachache is related to stress? I do not think that my kid [son] would have physical symptoms because of stress. My son also said that he had a stomachache for a long time when he went to school 2 years ago.

Most parents talked about gender-specific changes in their children’s behavior and personality characteristics as potential symptoms of depression, stating “boys were more likely to be violent and aggressive” and “girls were more likely to isolate themselves and to be oversensitive.”

Mothers’ comments exhibited gender-specific perceptions of their children’s symptoms. For instance, mothers noticed their daughters’ oversensitivity, thought that they should act as a bridge between daughter and father, and felt distressed about playing this role. One mother stated, “I have to play a role as a negotiator between my child and husband, because he does not know how to read the girl’s emotions.” In addition, mothers felt a strong need to be emotionally connected with their daughters, with one mom stating, “A mom has to be strong, because a mom influences a daughter a lot, and there is a special relationship and emotional connection between a mom and daughter.”

Mothers and fathers had different perceptions of depressive symptoms. Fathers thought that some depressive symptoms were typical female characteristics and tended to overlook them or expressed lack of understanding about how to deal with girls’ “sensitivity.” In general, fathers were the last to know about their children’s issues and typically cited the fact that they are
busy and stressed with their work as reasons for not noticing sooner. Although all parents indicated that fathers are the final decision makers about taking their children to a clinic, fathers often lacked knowledge about their children’s symptoms and their severity. In separate focus group interviews (M1 and F2), a married couple expressed differing viewpoints about taking their child to a mental health clinic:

Father: I was busy trying to make money so I did not know about my daughter’s issue until my wife told me. Now I’m willing to take her to a behavioral clinic, but before I understood her issue, I told my wife that I wouldn’t spend the money if insurance didn’t cover the treatment.

Mother: I felt my daughter has some issue because she did not eat and was very sensitive…. At the beginning, I thought she was on a diet like any other girl, but I felt something wrong and serious with her…. She looks like she was not pleased on anything.

Most parents stated that they delayed reacting to their children’s emotional and behavioral problems until those problems became apparent outside the home. They started to become alarmed when the school notified them about their children’s behavioral problems and peer conflicts. One father stated:

Actually, I was busy with work and making money in the U.S. And I kept saying to my children that I came to the U.S. for you, not for me. I also kept telling them not to make any trouble in school because I am struggling to work hard because of you. But when I got a call from school about my daughter’s behavioral problem, I started thinking that my daughter had some issues, because I pushed her and nagged her a lot.

Theme Four: Beliefs About Barriers to Treatment

Korean American mothers and fathers exhibited deeply rooted misconceptions about depression and its treatment that are common in the Korean American community and serve as barriers to seeking treatment. Parents also talked about other barriers to seeking mental health care services, including the difficulty of finding affordable care, insurance coverage, and availability in Korean:

Mother in M1: Everybody used to go to pediatricians, so they should know about this information [mental health resources that are covered by insurance or that are familiar in Korean culture].

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Mother in M1: I totally agree with what [other parent] said, because time is limited and [psychiatrists] they just listen and do nothing and… just make money.

When I received the referral from the pediatrician, I felt weird that I should go to one specific hospital. I felt suspicious that the doctor might have a connection with this hospital.

Medication….I am worried about people who should take medication in their lives. Medication might be addictive.

Most mothers expressed that counseling does not seem to be effective, because they could not see the positive outcomes in a short time. They believed referral to specialists (e.g., psychiatrists) was unnecessary, because the depressive symptoms were not considered to be serious enough to warrant care by a specialist. These beliefs, combined with perceived limited access to care, pose barriers to treatment.

Theme 5: Lack of Awareness of Intervention Pathways

Regarding knowledge about mental health resources, Korean American parents identified two types of resources for seeking help for depression: non-professional and professional help. The non-professional sources of help included their parents, churches, relatives, schools, self-help (for relieving stress), and other sources. However, acculturation acted as a main stressor for Korean American families. Acculturative stress hindered children and parents from talking about their depressive feelings and difficulties, because each family member did not want to burden the others who were busy adapting to their own environments, such as school, workplace, and the American community. Two mothers in M1 stated:

It’s weird living in the U.S. We are family, right? But here, each family member should do well on their own…. We cannot rely on each other. When we leave our home, tensions are everywhere. So all of us should do things on our own.

I thought I was the only one who suffers, but everybody does. [laughs] Immigrant families all have the same issue. All families should adjust to U.S. culture; children should adjust to school, and parents should adjust to jobs. That’s what immigrant families go through.

One M1 mother who had been treated for depression and another M1 mother who had a mother with depression both stated that non-professional help sometimes was not useful:

When I was depressed, I was hurt by others when they said, “Why do you feel lonely? What for?” I used to read a book, and the title was People Are Lonely Because They Are Human Beings. [Everybody laughs] And I felt that I needed to
find professionals. Only professionals could help me, not family or friends.

My mother also has depression. She said that she got hurt a lot when she heard that neighbors did not understand why she was depressed because her children lived well and there was nothing to be worried about.

Professional sources of help parents listed included hospitals (general and behavioral), medication, social workers, psychologists, teachers, counselors, psychiatrists, pediatricians, Korean welfare centers, and others. However, most participants did not know about mental health care services in their community. They stated if their children had a mental health problem, they would go to their children’s former pediatrician, whether Korean or American, because they did not know about more suitable resources, they had a long relationship, and mothers were accustomed to speaking with them. However, even with knowledge about sources of professional help, most mothers said that they were not sure that these resources would be necessary or helpful to improve their children’s symptoms. One M1 mother said:

I told my child to get help from a teacher. I know one psychiatric doctor, but she talks with my son for 30 minutes without being paid. [laughs] So she sees my child every week in church without asking to be paid…. She looks Korean culture well, so I trust her. But I don’t think that helps a lot. The school said my son needs to see a psychologist, but I don’t think that really treats my son’s condition [depression].

One M1 mother who has used mental health care services for her own depression expressed negative attitudes toward these services because she expected that her depressive symptoms would get better in three to five visits, and she did not see any improvement in her feelings after a few visits. Most participants agreed that treatment takes too long without doing anything but talking.

On the other hand, two fathers insisted that mental health care services would be somewhat helpful to their children even though the treatment works slowly. One father stated, “I know various professional resources such as Korean community centers, family, counselors, behavioral hospitals…. I believe that these resources would be better than nothing for helping my children.”

Korean American parents identified language, financial, and gender role barriers to seeking treatment for depression. Citing a language barrier, one mother said that she worried about seeing American doctors who she cannot communicate with due to her lack of English proficiency. Illustrating financial barriers, most mothers and fathers worried whether seeing a physician would be covered by insurance. They agreed that seeing a specialist (including a psychiatrist) is too expensive. As an example of a gender barrier, most mothers needed to receive their husbands’ approval for their children to see a physician because husbands made the money and were the ultimate decision makers about their children’s health care. Despite this fact, fathers were frequently the last to know about their children’s issues because they were unable to recognize their children’s symptoms and were themselves experiencing acculturative stress in their workplaces.

DISCUSSION

Korean American parents exhibited limited knowledge of the causes and symptoms of depression and expressed erroneous beliefs about depression and its treatment. In addition, some Korean American mothers did not recognize the significance of somatization in their children and treated it as an ordinary physical ailment. According to Cho and Bae (2005), unlike European and American Caucasian adolescents, Korean American adolescents tend to internalize emotional problems. Consequently, such problems might be manifested as somatization, which is more socially acceptable than emotional distress in Korean culture (Chun, Enomoto, & Sue, 1996).

Participants showed skepticism toward treatment for depression because they thought that counseling was not an effective treatment method, they feared that any medication could be harmful if high dosages were taken on a long-term basis, and they thought that antidepressant agents were addictive. Based on observations of individuals with depression in their communities—most of whom may have been ineffectively treated—participants believed that depression cannot be fully treated, relapses occur easily, and medication needs to be taken indefinitely. Such observations strongly influenced parents’ beliefs, suggesting that education about depression should include success stories from their own communities.

Gender played a role in perceptions of symptoms, as mothers noticed their daughters’ oversensitivity, but fathers thought that this was just a female characteristic. Parents tended to overlook their children’s depressive symptoms until they received cautionary notices from school staff. Even then, parents did not know how to help their children.

According to Jorm’s (2000) mental health literacy model, self-management of depression is especially important in minority groups because of their limited access to mental health care services due to language, financial, and cultural barriers. However, Korean American parents in the current study, even those who were interested in understanding the causes and treatment of their children’s depression, lacked knowledge about how to manage depressive symptoms. Therefore, depression education programs, tailored to the population’s depression literacy, are needed for Korean American parents.

In traditional Korean culture, relationships with one’s family and neighborhood affect one’s sense of well-being (Jo & Doorenbos, 2009). Collectivist cultural attitudes value group harmony more than individual concerns, so valuations of self and family are likely to be affected by social comparisons (Oyserman, Coon, & Kemmelmeier, 2002). Consequently, interventions
aimed at improving recognition and treatment of depression should address individual and group norms and beliefs. For example, educational programs that increase community awareness of depression and incorporate case studies of successful treatment may be effective in increasing social acceptance of depression and its treatment.

There is a compelling need for culturally sensitive education of Korean American parents about how to recognize and address depressive symptoms in their adolescent children. Educational programs offered in settings such as churches or barbershops, shown to be effective in African American communities (Releford, Frencher, & Yancey, 2010), may also be effective for Korean American individuals. Programs addressing depression should include its biological causes, the importance of taking prescribed antidepressant medication, coping strategies for dealing with symptoms, and professional resources and treatment success stories.

LIMITATIONS

Participants were volunteers recruited primarily from churches and a community center and may not be representative of all Korean American parents—even within the Chicago area. Parents who agreed to participate may have been more highly educated or socially connected and thus more comfortable sharing their opinions. Thus, the current findings may have been biased in that they might not reflect opinions of parents not engaged in the Korean community. In addition, only four Korean American fathers were willing to participate in the study, which limited the ability to explore male knowledge and beliefs about depression.

IMPLICATIONS

Korean American parents recognized that depression is a disease, but they lacked knowledge about its causes and treatments. They also held misconceptions about treatment of depression and negative attitudes toward use of mental health care services. Owing to their lack of knowledge about mental health care resources in their community, Korean American parents preferred to use non-professional help for their children’s depression. Thus, one implication of the findings is that there is a strong need for nurses to educate parents of adolescents with depression within their communities.

The five themes identified in the current study can be incorporated within existing depression literacy scales or used to develop a new scale. In future nursing research, items in the D-Lit scale developed by Griffiths, Christensen, Jorm, Evans, and Groves (2004) will be revised based on these findings. The 22-item D-Lit scale developed by Gulliver et al. (2012) showed acceptable reliability, including adequate internal consistency (Cronbach’s alpha = 0.70) and test–retest reliability ($r = 0.71$), for a sample of 40 Korean American adults. Based on the findings from the focus group interviews, new items reflecting culturally grounded depression knowledge and beliefs can be included in this scale. Because all participants lacked knowledge about the biological cause of depression, they were skeptical that medication would be effective in treating the condition. Therefore, the following items could be added to the scale: “The cause of depression is poor parenting and child characteristics rather than brain-related problems,” and “If there is an imbalance in brain chemicals or hormones, it can cause depression.”

Because all participants lacked knowledge about the biological cause of depression, they were skeptical that medication would be effective in treating the condition. 

These culturally grounded items could enhance the reliability and validity of the D-Lit scale for nurses’ use in assessing depression literacy with the Korean American population.

Regarding implications for recruitment of Korean American participants in future studies, some