CULTURAL ADAPTATION OF A PREVENTION PROGRAM OF KOREAN AMERICAN PARENTS OF ADOLESCENTS

by

Naomi Pak

A Dissertation
Submitted to the
Graduate Faculty
of
George Mason University
in Partial Fulfillment of
The Requirements for the Degree
of
Doctor of Philosophy
Psychology

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Date: _____	Spring Semester 2022 George Mason University Fairfax, VA

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Spring Semester 2022
George Mason University
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ABSTRACT

CULTURAL ADAPTATION OF A PREVENTION PROGRAM OF KOREAN AMERICAN PARENTS OF ADOLESCENTS

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Asian American (AA) adolescents experience significant mental health concerns that are often overlooked and masked by cultural values. Due to the intergenerational acculturation conflict between parents and their children, second-generation AAs are particularly vulnerable to poor psychological outcomes and low utilization of mental health services. While there are existing programs targeting mental health problems by promoting parent-child relationships, a culturally adapted web-based parent training (PT) program for first-generation Korean American (KA) parents of second-generation adolescents does not exist. To address this gap in the literature, the present dissertation describes two studies that aimed to culturally adapt two existing PT programs for first-generation KA parents of teens. In Study 1, KA parents participated in two semi-structured focus groups to gather feedback after reviewing the initial Korean Family Communications (KFC) Program manual and the subsequent revised manual.

Additionally, researchers consulted with a community KA mental health professional to best incorporate the focus group feedback. The following themes emerged: filial piety, communication, perception of Korean values, misconceptions about mental health, and stigma. The Korean Family Communications manual was revised according to feedback. In Study 2, The KFC Program was piloted to a sample of 10 KA parents. Preliminary results demonstrated that the program improved mental health literacy and attitudes towards seeking services. The program was accepted and well-received by KA parents.

INTRODUCTION

Asian Americans (AAs) are one of the fastest growing racial groups in the United States, accounting for 7% of the country's population (Pew Research Center, 2021). With a reputation as the "model minority," AA mental health is often overlooked and masked by deeply rooted cultural values. However, AAs experience a significant degree of mental health issues including substance use disorders, anxiety disorders, or depression (Alegria et al., 2005; Choi et al., 2020; Hai et al., 2021; Oh & Yamada, 2020). Second-generation Asian-American offspring are of particular concern due to the intergenerational acculturation conflict (IAC) with their first-generation parents caused by acculturation mismatch (AM). Previous research has found that IAC is associated with poorer mental health outcomes among this population (Lui, 2015). Additionally, differing cultural values negatively impact adolescent emotional regulation, which leads to anxiety symptoms, aggressive behavior, and eating pathology (Liu & Goto, 2007; McLaughlin et al., 2011; Park et al., 2010). Due to cultural pressures, AAs are reluctant to seek the mental health services they need (Abe-Kim et al., 2007; Lee & Jang, 2015). In this dissertation, we will specifically focus on Korean Americans (KAs), one of the largest AA populations in the United States with the poorest mental health outcomes and lowest rates of seeking help (Park et al., 2016; Yeh & Inose, 2002; Yeh, 2003). It is important to

note that many research studies group together AAs together, including KAs. Therefore, we will discuss research on AAs as well as, specifically, KAs.

While there are existing parent training (PT) prevention programs targeting mental health problems by promoting parent-child relationships, these programs are either aimed at parents of toddlers/younger children, developed based on Western values, and/or require extensive time (Buchanan-Pascall et al., 2018; England-Mason & Gonzalez, 2020). The few existing PT programs for KA parents focus on parent-child relationships, family empowerment, coping skill use, psychoeducation, and/or mental health stigma for parents of younger children or no age specificity as well as for parents with severely mentally ill children (Kim et al., 2008, 2014; Shin, 2004). No PT program exists that addresses mental health stigma, mental health literacy, parent-child communication, and attitudes towards seeking services for KA parents with specifically adolescents. KA parents with second-generation adolescents have unique needs due to the IAC in their families. Therefore, there is a need for a PT program targeting first-generation KA parents with second-generation teenagers to decrease stigma, increase mental health literacy, increase attitudes toward seeking services, and improve parent-child communication (Hamari et al., 2021).

Psychopathology of Korean American Adolescents

Beginning in the 1960's, AAs were classified as the "model minority," a minority group that has achieved high levels of educational, occupational, and economic success compared to other ethnic counterparts in the United States (Pettersen, 1966). Along with their lower reported rates of mental health concerns and utilization of services, AAs were

deemed well-adjusted and model minorities (Leong, Juang, Qin, & Fitzgerald, 2011). However, this stereotype has been countered by evidence revealing significant mental health concerns that are similar, if not higher, than non-Asian Americans. (Leong et al., 2011). According to The National Latino and Asian American Study (NLAAS), this population does, in fact, experience a significant degree of mental health issues with an overall lifetime rate of 17.3% for substance use disorders, anxiety disorder, or depression (Alegria et al., 2004; Vilsaint et al., 2019). Additionally, data from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) found that the 12-month prevalence rate of any psychiatric disorder was 23.6% for AA males and 22.3% for AA females (Hasin & Delker, 2015).

Regarding depression, previous research specifically examining the mental health of AA adolescents showed that this group reported higher levels of depressive symptoms, withdrawn behavior, social problems, poor self-perception, and dissatisfaction with their social support compared to their Caucasian-American counterparts (Choi et al., 2020; Kim & Cain, 2008; Lorenzo, Frost, & Reinherz, 2000). They also reported the highest rates of depressive symptoms and suicide of any ethnic group (Kim & Cain, 2008b). Specifically for KA adolescents, research has found that this population has higher depression scores and somatic symptoms than Caucasian and other AA teens (Brown et al., 2007; Choi et al., 2002; Lee et al., 2000). Kim and Cain (2008) found that approximately 40% of Korean American adolescents, both girls and boys, experienced depressive symptoms. It is important to note that Koreans tend to express their psychological distress through the body rather than the mind such as nausea, tense

muscles, lack of appetite, and headache, which is more culturally acceptable (Park & Bernstein, 2008). These physical symptoms often lead to seeking medical consultation when, in fact, the symptoms are a manifestation of psychological distress.

Similar to the findings on depression, research has found that AAs were more likely to experience anxiety than their Caucasian counterparts (Gee, 2004; J. Lee et al., 2000). For Asian American adolescents, early symptoms of anxiety may be physical complaints (ex. headache, stomachache), difficulties with sleep, appetite changes, and poor school performance (Huang, 1997). Research on AA teens found that high anxiety symptoms predicted increased depression over time (Arora et al., 2017). KA teens, in particular, experience significantly high levels of anxiety as predicted by variables including poor self-esteem and greater severity of conflict with parents (Cho & Bae, 2005).

Previously theorized as a culture-bound syndrome afflicting predominantly upper-middle-class White women, eating pathology affects people of all ethnicities and genders, including AAs. In fact, research has found that AAs are at particular risk of developing eating problems and body image issues (Claudat et al., 2016). In a meta-analytic review of the role ethnicity and culture play in the development of eating pathology, Asian samples reported more eating disturbance, body dissatisfaction, greater dietary restraint, and weight and dieting concerns compared to their White counterparts (Wildes et al., 2001). Results from a study examining disordered eating among AA women showed that those who internalized Western media beauty standards were more likely to experience body dissatisfaction and disordered eating (Cheng, 2014).

Regarding substance use, AA adolescents have lower rates of alcohol (4.0%), cigarette (1.8%), and marijuana use (0.8%) compared to other ethnic groups (Hai et al., 2021; Shih et al., 2015). However, compared to other AA adolescents, KA teens experience the highest levels of substance use (Caraballo et al., 2006; Cook et al., 2009). An epidemiological study found that among KA adolescents, 48% have consumed alcohol 2-3 times in their lifetime, 31.6% have smoked cigarettes in the past year, and 11.1% have used marijuana in their lifetime (Price et al., 2002). Despite the overall low prevalence rates, research has found that when AA teens do engage in alcohol consumption, they are more likely to engage in delinquent behavior (i.e. skipping class, getting sent to the principal for bad behavior, taking money, beating someone up, and carrying a weapon) and illicit drug use compared to White teens (Barnes et al., 2002). The three most common substances used among Korean American teens are alcohol, marijuana, and cigarettes (Fang et al., 2011).

Regarding alcohol use, a research study found that the majority of KA teens have tried alcohol in their lifetime (66.3% female, 75.3% male) with 14 as the average age of first drunkenness for both boys and girls (Nakashima & Wong, 2000). No gender differences were found for alcohol use or misuse (Nakashima & Wong, 2000). The most common situations where KA teens drank alcohol were at night with friends, at parties, and at home when parents didn't know (Nakashima & Wong, 2000). This study also found that 19.9% experienced at least one negative consequence from alcohol. The 3 most frequent consequences were passing out (11.8%), breaking something (11.8%), and fighting with other teens (10.5%) (Nakashima & Wong, 2000).

In general, adolescents begin to smoke marijuana around the first year of high school where they have more access (Fang et al., 2011) and marijuana use increases significantly by 12th grade (Otsuki, 2003). Compared to other AA subgroups, KA adolescents had the highest initiation rates for marijuana use (Shih et al., 2015). Substance use initiation is important because the earlier a person starts using substances, the risk for illicit drug and alcohol use, addiction (King & Chassin, 2007), low academic motivation (Ellickson et al., 2004), antisocial behavior (McGue et al., 2006), and long-term neurological consequences increases (Tapert et al., 2008).

For cigarette use, a study found that depression and friends' use of cigarettes significantly predicted a teen's own use (Otsuki, 2003). Compared to other AA subgroups, KA adolescents had the highest initiation rates for cigarette use (Shih et al., 2015) with above average use by 12th grade (35.9% males, 29.4% females) (Otsuki, 2003). Research has found that truancy (skipping school) increased the odds of cigarette smoking while academic self-esteem protected against this behavior among AA teens (Yang et al., 2013). The prevalence and severity of psychopathology among KAs are clearly higher than previously reported or assumed for this "model minority" group (Oh & Yamada, 2021).

Development of Psychopathology in Korean American Adolescents

The specific cultural mechanisms must be understood to effectively adapt a prevention program for first-generation KA parents of second-generation adolescents. A degree of increased discord in parent-child relationships during adolescence is typical due to the developmental changes of seeking autonomy, focusing on peer relationships,

creating identity outside of family, learning to effectively regulate emotions (Christie & Viner, 2005). However, studies have found that significant conflict during adolescence may have harmful effects such as depression, substance use, and delinquency on the teen (Steinberg & Morris, 2003). Compared to non-immigrant families, this friction is particularly more severe and problematic within AA families because of the IAC (Moon, 2008).

Acculturation is a process where immigrants adjust to new cultural customs from their host country while maintaining their heritage cultural values and norms (Berry, 2006; Lee, Sobal, & Frongillo, 2003). The differences in the acculturation process for each family member impacts the dynamics of intergenerational relationships (e.g. family roles, parenting styles, and intergenerational conflict), specifically between first-generation AA parents and their second-generation adolescents (Bornstein & Cote, 2006). Parents are more likely to maintain and practice traditional values, whereas their U.S.-born teenagers tend to embrace mainstream norms due to peer socialization and typical adolescent development in individuation and autonomy (Lui, 2015), which results in acculturation mismatch. The following are specific mechanisms of acculturative gap that lead to problematic outcomes: 1) increased acculturative stress in those less acculturated, 2) conflict between family members at different levels of acculturation, 3) loss of culturally protective factors among those more acculturated (Hwang & Wood, 2009; Liu & Goto, 2007).

As the acculturation gap grows between the parent-offspring dyad, there is a tendency for intergenerational acculturation conflict (IAC) to develop (Kim & Park,

2011). IAC occurs due to a clash between parents and their children over differences in acculturation, a concern frequently reported by AA youth (Choi, He, & Harachi, 2008; Choi et al., 2020). The distinct juxtaposition between Western individualism and Confucian collectivism create conflict within families. Previous studies have examined the generational differences in customs in various domains including parenting styles, importance of education, emotional expression, collectivism, filial piety, and communication (Kim et al., 1999; Oak & Martin, 2000; Shrake, 1996; Uba, 1994).

Collectivism

East Asian culture is deeply rooted in Confucian philosophy that emphasizes collectivism (Markus & Kitayama, 1991). Collectivistic cultures value group conformity, suppression of conflict and emotion, and social obligation to maintain harmony within the group (Leong et al., 2011). Members of collectivistic societies develop a strong in-group (family) identity where the in-group is seen as an extension of the self (Triandis, Leung, Villareal, & Clack, 1985). This differs from Western individualistic values by encouraging self-control and conformity to family/community and considers those who rebel from the family system as weak and characterless deviants (Sue et al., 1976). As KA adolescents are acculturating to Western individualistic culture, they are distancing themselves from the value of collectivism, which research has found to be a culturally protective factor against negative psychological outcomes (Liu & Goto, 2007; Park et al., 2010). Collectivism may act as a protective factor because those who define the self in a relational manner may be reluctant to engage in harmful behaviors that could potentially disrupt social harmony (Liu & Goto, 2007).

Authoritarian Parenting

Based on Confucian philosophy, Korean parenting is traditionally authoritarian, emphasizing distance between parents and offspring to maintain respect for parents (Oak & Martin, 2000). Korean parenting is characterized by a lack of physical and verbal affection, a lack of communication, and importance of absolute obedience (Kim, 2005). Compared to Caucasian American parents, KA parents do not express warmth to children through positive physical or verbal expressions and provide less emotional coaching (Nahm, 2007). Harsh discipline is used to manage misbehavior with intrusive involvement among KA parents (Kim & Hong, 2007; Nahm, 2007). In contrast, American parenting typically involves positive discipline by rewarding desired behaviors, displaying warmth (i.e., hugging and praising), reducing undesired behaviors (i.e., ignoring, timeouts), and focusing on positive parent-child relationships (Wolraich et al., 1998). Studies have found that positive discipline is related to children's self-esteem, prosocial skills, academic performance, and peer relationships (Patterson, Reid, & Dishion, 1992). The harsh discipline and lack of warmth in the authoritarian parenting style has been associated with adverse effects on internalizing and externalizing problems for children (Shrake, 1996). The American Academy of Pediatrics recommends positive and appropriate discipline rather than harsh punishment; however, immigrant parents are unfamiliar with these strategies, so they have difficulty implementing them (Kim et al., 2008a; Wolraich et al., 1998). The parenting practices developed to fit Korean society do not fit well within the American social context (Kim et al., 2008a). The mismatch in parenting values and social contexts increases conflicts between KA parents and their

Americanized children, which have been found to result in negative psychological outcomes for the offspring (Kim & Cain, 2008).

Emotional Expression

There are distinct differences in emotional expression between Western and Confucian cultures. Confucian philosophy encourages emotional suppression to maintain social hierarchy and collectivism (Oak & Martin, 2000). Previous research found that cultures that value embeddedness and hierarchy tend to have higher scores on suppression compared to those that emphasize individualism and autonomy (Matsumoto et al., 2008). Emotional suppression is demonstrated in KA parenting through the lack of verbal and physical affection. The Confucian way of showing affection involves parents providing clothes, housing, food, and education for their children (Oak & Martin, 2000). KA parents are not used to expressing warmth through hugs, kisses, praise, and saying "I love you," which are typical ways of displaying affection in American parenting (Kim & Hong, 2007). Due to Confucian philosophy of emotional suppression, this type of emotional expression is difficult for them and does not come naturally. While research has found that emotional suppression is associated with negative social consequences (i.e., avoidant attachment, lower social support, lower peer-rated likeability, reduced relationship closeness, reduced sharing of emotions), cultural values moderated the relationship showing that those with Asian values did not experience the problematic effects of habitual suppression (Butler et al., 2007). Therefore, the negative consequences of emotional suppression are of concern when the behavior and values do not align which is a common experience among acculturated AA adolescents. When AA adolescents with

American values of emotional expression are forced to engage in emotional suppression due to cultural expectations enforced by their parents, negative mental health outcomes occur (Butler et al., 2007; Liu & Goto, 2007; Park et al., 2010).

Filial Piety

Another important difference between Eastern and Western cultural values is filial piety. Based on the Confucian philosophy of hierarchical relationships and obedience to authority, one must obey and respect parents and elders unconditionally (Kim & Hong, 2007; Kim & Wolpin, 2008). The filial piety involves authority of fathers, wives' obedience to husbands, children's obedience to parents, filial piety submission of self to family, submission to civil authorities, and high expectations in education (Lehrer, 1996). While Western culture values respecting authority, it also encourages individual thought and expressing one's opinion which are considered disrespectful in Korean culture when directed at parents or elders. KA adolescents are expected to obey without talking back or questioning authority (Kim & Hong, 2007). Generally, KA adolescents acculturate faster than their parents, which leads to acculturation mismatch and threatens the hierarchical relationship between parents and adolescents (Choi, 2002; Lee, Choe, Kim, & Ngo, 2000)

Communication

In Confucian philosophy, communication is unidirectional where parents instruct children with the expectation of unconditional obedience and no discussion (Choi, 2002). In contrast, Western culture promotes bidirectional communication, assertiveness, and verbal expression of one's opinion (Kim & Cain, 2008). KA parents view this behavior as

problematic, rebellious, and disrespectful (i.e., talking back to parents) (Choi, 2002). Behavior that is normally accepted in the American school setting is reprimanded at home, creating parent-child conflict due to the acculturation mismatch and subsequently leads to poor mental health outcomes for KA adolescents (Kim & Cain, 2008).

Additionally, there are significant differences between the Korean and English language that results in miscommunication between parent and adolescent. Based on collectivism, Korean communication is situation- or other-centered (Kim, 1985). Koreans view themselves as part of the larger social system. They emphasize subtle, nonverbal communication. Facial expressions also tend to be more stoic because this non-expression is considered virtuous (Kim, 1985). Whereas Americans communicate in a self-centered or individualistic way where they view the individual as the center (Kim, 1985). They express themselves in direct, verbal ways. Visible and obvious facial expression are expected in social situations. While American communication relies more of the actual words exchanged to convey ideas and messages, Korean communication tends to be focused on the subtle ability to listen and sense what people are thinking and feeling (Kim, 1985). Because KA adolescents are growing up with English as their primary language, they often misinterpret the intention and meaning behind the Korean spoken by their parents. This miscommunication often results in parent-child conflict and negative emotions.

Importance of Education

Confucian philosophy places high importance on education (Lee, 2004). In a previous study, 80% of KA mothers viewed a “B” as a bad grade when a “B” in

American schools is considered above average (Shrake, 1996). KA parents have high expectations of academic and occupational achievement in their children, creating significant tension within KA families compared to White parents (Ang & Huan, 2006; Lee at al., 2009; Jo, 1999). While KA parents demand and expect high grades, they do not provide their children with academic assistance to help them success due to their limited time and English (Steward & Steward, 1973). Research has found that KA adolescents who fail to satisfy their parents with good grades tend to feel shamed, depressed, and suicidal (Choi, 2002; Kaderlan-Halsey, 2003).

The acculturation gap-distress theory posits that differences in acculturation behavioral preferences, cultural values, and self-identities creates distance between immigrant parents and their offspring leading to IAC, which results in poorer offspring psychological functioning (Choi et al., 2020; Yasui, Kim & Choi, 2018). Previous research has found that IAC is associated with decreased family cohesion and satisfaction, greater family conflict, and subsequent negative mental health outcomes in KA adolescents (Crane et al., 2005; Hwang & Wood, 2009; Lui, 2015; Park et al., 2010; Portes & Rumbaut, 1990). Parent-child conflict predicted depression, somatic symptoms, anxiety, anger, deviant behavior, and suicide among KA adolescents (Sangmi Cho & Bae, 2005). KA adolescents report higher levels of depression than their White counterparts and the highest level of anxiety, aggression, and somatic symptoms among AA adolescents (Choi et al., 2002; Yeh, 2003). Regarding substance use, KA teens report the highest prevalence of current cigarette smoking, alcohol consumption, and habitual alcohol (Caraballo et al., 2006). Of note, ethnic identity was found to be a significant

moderator of IAC and internalizing problems, acting as a buffer (Lee & Koeske, 2010). Maintenance of Korean identity and traditions decreases the acculturation gap, leading to better mental health outcomes among KA adolescents (Oh, Koeske, & Sales, 2002).

Current Dissertation Aims

With the highest rates of mental disorders among AA teens, KA adolescents are a particularly vulnerable population due to the cultural factors that influence mental health stigma, mental health literacy, attitudes towards help-seeking, and family communication. Despite previous research on KA adolescent mental health, there are no existing culturally specific, prevention programs designed to address the cultural factors of collectivism, "saving face," emphasis on somatic symptoms, misconceptions about mental health, and perceived stigma to target these outcomes within the KA population (Jeong et al., 2018). The purpose of the proposed study is to fill a significant gap in the KA mental health literature.

In the present dissertation, we conducted two studies aimed at developing a web-based prevention program for first-generation KA parents of second-generation adolescents by culturally adapting existing PT programs [Project SHAPE program (Esposito-Smythers et al., 2017) and Stepping Stone (Choi et al., 2016)]. As psychoeducational interventions for KAs were found to significantly decrease stigma, improve empowerment during crises, and increase coping skills (Shin, 2004), we focused on providing culturally competent psychoeducation as the program's core mechanism of change. In Study 1, based on the literature, we developed a cultural adaptation of the two prevention programs (Project SHAPE and Stepping Stone) and named it the Korean

Family Communications (KFC) Program. Two rounds of focus groups were conducted with stakeholders (i.e., first-generation parents of second-generation teens and a KA community therapist) to receive feedback on the content, acceptability, and feasibility of the adapted program protocol. Following Study 1, the adapted protocol was finalized and developed into a web-based program in both English and Korean. In Study 2, the KFC program was piloted with first-generation KA parents of second-generation adolescents to assess its acceptability, feasibility, and preliminary effects. Twenty-six participants enrolled and completed pre-intervention questionnaires. Eleven completed the entire program and post measures. Based on the literature review, one target for prevention efforts is IAC, as this leads to negative outcomes for KA teens. In order to target IAC, KA parents must be involved. This prevention program was specifically designed to address mental health literacy, stigma, communication, and attitudes towards seeking mental health services in KA parents, with the hope that this will have an impact on IAC and later teen outcomes.

STUDY 1. CULTURAL ADAPTATION OF A PREVENTION PROGRAM FOR KOREAN AMERICAN PARENTS OF ADOLESCENTS: FOCUS GROUPS

While there are existing PT prevention programs targeting child mental health problems, the majority are developed for and by Western people and their values (Dinkmeyer & McKay, 1976; Gordon, 1980; Schuhmann et al., 1998). Programs developed based on research on mostly White samples do not account for the language, values, customs, child-rearing traditions, expectations for child and parent behavior, and distinct cultural stressors and resources unique to specific cultures, which negatively impacts engagement and outcomes (Spencer-Rodgers & Peng, 2004). Additionally, existing PT's primarily focus on improving family communication, decreasing externalizing and internalizing problems, and improving parental discipline methods (Buchanan-Pascall et al., 2018; Dinkmeyer & McKay, 1976; D. A. Gordon, 2000; T. Gordon, 1980; Gross & Grady, 2002; Lochman, 2000; Schuhmann et al., 1998; Wetterborg et al., 2019; Yap et al., 2016). These programs fail to address the unique cultural barriers of KAs to target mental health literacy, stigma, parent-child communication, and attitudes toward seeking services (Buchanan-Pascall et al., 2018; Dinkmeyer & McKay, 1976; D. A. Gordon, 2000; T. Gordon, 1980; Gross & Grady, 2002; Lochman, 2000; Schuhmann et al., 1998; Wetterborg et al., 2019; Yap et al., 2016). The present study aimed to culturally adapt an existing prevention program through

modification, supplementation, and incorporation of cultural values to focus on the specific needs of the KA population.

Cultural adaptation is a systematic process of modification aiming to make the intervention compatible with the target population's cultural patterns, meanings, and values (Bernal & Sáez-Santiago, 2006; Movsisyan et al., 2019). In this context, 'intervention' refers to both treatment intervention and prevention programs. Based on the three levels of prevention programs, we developed a selective preventative program that targets a group of people who fall at a higher than average risk of developing mental health problems, but are not yet diagnosed (National Research Council, 2009). While there are various intervention adaptation models, we used Lau's (2006) data driven adaptation framework to inform cultural adaptation to the map of adaptation process (i.e., assessment, selection, preparation, pilot, and implementation) posed by McKleroy et al. (2006). Lau's framework is based on behavioral research that addresses sociocultural risk patterns, resilience, mental health presentation, and attitudes towards common therapeutic practices in culturally diverse communities (Lau, 2006). Lau utilizes a selective and directed approach to cultural adaptation of evidence-based treatments (EBT's) for targeted communities: 1) selectively identify target problems and populations that would benefit from an adapted intervention due to evidence of the likelihood of EBT generalization failure and 2) direct the design of treatment adaptations using a data-driven, a posteriori approach to determine how fit of the EBT may be improved for the target cultural group (Lau, 2006).

The phases of program adaptation for the present study involved the following steps using Lau's selective and directed approach: assessment, selection, and preparation (McKleroy et al., 2006). To adapt an intervention for a specific population, one must define the problem, assess the target population, examine the available evidence-based interventions (EBIs), survey the opinions of stakeholders, determine organizational capacity, select the final EBI, make necessary changes, prepare organization, and pre-test. We followed these steps by identifying target problems within the KA community using the selective approach, picking the most appropriate PT prevention program to modify and adapt to meet the needs of the target population, developing an evaluation protocol to assess therapeutic efficacy, and then piloting the adapted program (Lee, Altschul, & Mowbray, 2008; McKleroy et al., 2006; Wight, Wimbush, Jepson, & Doi, 2015).

Furthermore, for successful intervention adaptation, partnerships between researchers and stakeholders (i.e. the target population, practitioners, and other organizational personnel) are critical (Murry & Brody, 2004; Nastasi et al., 2000). To recruit stakeholders for the focus group, we utilized our connections with the George Mason University Center for Psychological Services, the Washington Multicultural Counseling Center at Washington University of Virginia, the Fairfax County Consortium for Evidence-Based Practice, the Asian American Psychological Association, and the Korean Community Service Center. These stakeholders were involved in the intervention adaptation process by providing a greater understanding of the problem, institutional limitations, and program feedback. As a byproduct of stakeholder involvement, program acceptability develops through the partnership, which plays a vital role in the

implementation process with the target population (Nastasi et al., 2000). It is important to note that developing or adapting an intervention is a non-linear, iterative process that involves repeating previous steps and making necessary changes to ultimately create the optimal program (O'Cathain et al., 2019). Therefore, the present study is just the beginning of an ongoing process. Study 1 focused on the assessment, selection, and preparation phases of the adaptation process.

Problem Identification

First, we defined the problem: there are no existing culturally adapted PT programs designed to address cultural barriers that influence mental health stigma, mental health literacy, attitudes towards help-seeking, and family communication for first-generation KA parents of second-generation teens despite research on these barriers and the high prevalence of mental health problems within this population. Next, we examined theoretical frameworks for the development of psychopathology among KA adolescents and selectively identified target problems and culturally specific barriers that increase the likelihood of EBT generalization failure. Based on review of the literature, researchers found that second-generation KA offspring are particularly vulnerable to developing mental health problems due to the intergenerational acculturation conflict (IAC) with their first-generation parents caused by acculturation mismatch (AM) (Crane et al., 2005; Hwang & Wood, 2009; Park et al., 2010). Specifically, Westernized KA adolescents and their traditional parents differ in their views on parenting style, importance of education, emotional expression, collectivism vs. individualism, filial piety, and communication. Previous research has found that IAC is associated with

poorer mental health outcomes among this population (Lui, 2015). Due to cultural values, KAs are reluctant to seek the mental health services they need (Ying & Hu, 1994).

Influence of Cultural Values on Service Utilization

Collectivism

Based on Confucian philosophy, collectivism is deeply engrained in East Asian culture, which emphasizes group conformity, suppression of conflict and emotion, and social obligation to maintain harmony within the group (Leong et al., 2011; Markus & Kitayama, 1991). Differing from the Western individualistic values, collectivism encourages self-control and conformity to family/community and negatively views those who defy against the family system (Sue et al., 1976). Because of these factors, Western models of psychotherapy that explore highly emotional content, encourage open verbal communication, and focus on the individual are incongruent with collectivistic values; consequently, creating a barrier to seeking mental health services (Arkoff, Thaver, & Elkind, 1966; Leong & Lau, 2001; Sue & Sue, 1977). Of note, forced collectivistic values contribute to the development and suppression of psychological symptoms due to acculturation mismatch. However, personally identifying with the cultural value of collectivism may serve as a protective factor against mental health problems (Liu & Goto, 2007; Park et al., 2010). Depending on the context, collectivism may function as a barrier and/or protective factor; therefore, this cultural value must be targeted.

"Saving Face" and Perceived Stigma

The concept of "saving face" is another cultural value that plays a role in the reluctance to seek mental health services among AAs. "Face" is the value a person claims

based on approved social attributes associated with morality, honor, dignity, prestige, and status (Goffman, 1955). Face is lost when a person fails to meet the social standards through their own actions or by those closely related (Goffman, 1955). Experiencing psychological distress may be construed as personal weakness, immaturity, and a hereditary flaw, and these culturally-laden interpretations are generalized to indicate inadequacies of the individual's support system (i.e. family) (Shea & Yeh, 2008). Therefore, psychological distress results in shame, stigma, and loss of face for the entire group. Due to the importance of "face" and the family name in collectivistic culture, individuals tend to turn towards their families first for help because they view mental health professionals as part of the outgroup (Ho, 1984; Kim & Choi, 2010; Webster & Fretz, 1978). They prefer to keep information about family problems private because they perceive personal disclosures, especially regarding psychological distress, as bringing shame to family members and the community (Ho, 1984). Reporting mental health issues among AAs are low due to feelings of shame and stigma associated with psychological difficulties (Root, 1985). The emphasis on "saving face" have led to the stigmatization of mental health due to the lack of open communication about these psychological experiences.

Mind-Body Holism

Asian culture's widely-held concept of mind-body holism contributes to the somatization of psychological symptoms and tendency to seek medical services rather than mental health services (Leong & Lau, 2001; Sue et al., 1976). Because mind-body holism suggests that there is no clear distinction between psychological and physical

ailments (Leong & Lau, 2001), AAs are more likely to rely on medical professionals for their psychological problems, a more culturally-acceptable profession and service (Sue et al., 1976). Additionally, due to concerns about "saving face," AAs, either consciously or unconsciously, express their psychological distress through the body rather than the mind (U.S. Department of Mental Health and Human Services, 2001). Seeking medical services for somaticized psychological symptoms allows AAs to "save face," maintaining their cultural values.

Willpower

While Western beliefs about the etiology of mental disorders are based on the biopsychosocial model, collectivistic cultures believe in organic, sociologically oriented explanations (i.e. American culture and experience of prejudice) (Sue et al., 1976; Yeh, Hough, McCabe, Lau, & Garland, 2004). Previous research found that AAs are more likely than Caucasian Americans to believe that willpower and self-control are the basis of personal adjustment and therefore, in order to improve one's mental health, an individual must simply exercise his/her willpower to avoid negative thoughts and focus on pleasant ones (Arkoff et al., 1966; Sue et al., 1976). The inability to do this is considered a personal weakness and lack of self-control. Therefore, Western models of certain psychotherapies that explore negative emotions do not align with Asian cultural beliefs of avoidance (Leong & Lau, 2001; Sue & Sue, 1977). Due to the cultural approach to the etiology of mental disorders and importance of willpower, AAs view those with mental illness and those who seek treatment in an undesirable light.

Help-Seeking Behavior Among Asian Americans

With evidence demonstrating the significant mental health needs for AAs, it is concerning that data from the National Latino and Asian American Study (NLAAS 2002-2003) found that AAs exhibited lower rates of seeking mental health services compared to the general population at only 8.6% (Abe-Kim et al., 2007). The National Epidemiological Survey on Alcohol and Related Conditions (NESARC 2001-2002) study found that only 25% of AAs with a DSM-IV diagnosis sought services (Lee, Martins, & Lee, 2014). Additionally, AAs have been found to experience higher levels of early termination, worse short-term outcomes, and poorer satisfaction with care when compared to non-Hispanic Whites (Stanley Sue & McKinney, 1975). While cultural values significantly contribute to the reluctance to seek services (Jang et al., 2009; Ying & Hu, 1994), culturally unresponsive services, limited access to care, and lack of awareness/understanding of services also account for AAs minimal help-seeking behavior (Tsai & Yeh, 2011).

Culturally Unresponsive Services

With traditional collectivistic values emphasizing group needs over individual needs, Western psychological treatment that encourages autonomy, open communication, as well as, verbal and nonverbal emotional expression conflict with Asian conservative beliefs (Yeh & Kwong, 2009). The difference in values lead AAs to question the credibility of these services, resulting in avoidance or premature termination of treatment (Gim et al., 1991). Researchers have found that AAs, including Korean immigrants, view conventional therapy as ineffective, costly, intrusive, and time consuming and prefer

directive, structured, problem-solving approaches that focus on alleviating symptoms (Park & Bernstein, 2008). Additionally, lack of language match, lack of ethnic match, and poor cross-cultural understanding in mental health services contribute to low help-seeking behaviors among AAs. Sue and colleagues (1991) found that AA clients who were with AA therapists were less likely to terminate prematurely and remain in therapy longer than those who were not ethnically matched. Speaking the client's language, understanding their cultural experience, and having bicultural skills are also elements of providing culturally-specific services (*Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*, 2001). KAs identified that the lack of culturally appropriate therapeutic interventions was one of the barriers keeping them from seeking mental health services (Cho et al., 2013). The evidence shows that this community responds poorly to certain EBT approaches due to the culturally unresponsive services, demonstrating the KA population as a community in need for a culturally adapted program (Lau, 2006).

Limited Access to Care

Due to the dependence on health insurance, mental health services are often inaccessible to those in need of treatment. About 21% of AAs and Pacific Islanders do not have health insurance (*Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*, 2001). The rate of Medicaid coverage for most AAs and Pacific Islanders is well below that of Caucasian Americans (E. R. Brown et al., 2000). Along with the lack of health insurance coverage, the inaccessibility

to nearby mental health services is another commonly reported barrier for this group (Uba, 1994), limiting access to services and utilization of healthcare (Chin et al., 2000).

Lack of Awareness/Understanding of Mental Health

The lack of awareness and acknowledgment of mental health problems in Asian culture make the subject taboo. The stigmatization of psychological distress results in misinformation about mental health and associated services (Augsberger et al., 2015). Common misconceptions about mental health include perceived stigma from others, utilizing willpower, and mental disorders as fake/made-up. These myths reinforce AAs underutilization of mental health services.

Although previous research has examined the development of psychopathology among KA adolescents and cultural barriers to seeking services, there are no existing culturally adapted PT programs designed to address these cultural factors within the KA population. Therefore, the aim of Study 1 was to conduct semi-structured focus groups and professional consultation with various stakeholders (i.e., parents and professionals) to receive feedback on the content, acceptability, appropriateness, and feasibility of a culturally adapted PT program (KFC Program) specifically designed for first-generation KA parents of second-generation adolescents.

Examination of Existing Parent Training Prevention Programs

While there are many PT programs, few have been culturally adapted or specifically designed for the KA population. The Parent Effectiveness Training (P.E.T.) Program is a 24-hour intensive, skills-based PT program designed to improve family relationships by improving communication skills (Gordon, 1962). When conducted with

Korean parents, the P.E.T. program improved parent-child and spousal communication, but not flexibility (Kang & Kim, 2013). Of note, this program was administered to Korean parents, not KA parents, which does not address the IAC factors that uniquely impact communication within KA families. Parent-Child Interaction Therapy (PCIT) is another PT program which focuses on behavioral interventions for children aged 2-7 years and their parents to decrease externalizing behavior problems, increasing child social skills and cooperation, and improving parent-child attachment (Schuhmann et al., 1998). When the PCIT was conducted with Chinese parents and their children, Leung et al. (2009) found fewer child behavior problems, parenting stress, increased positive parenting practices, and decreased inappropriate child-management strategies. Although the results were positive, PCIT was administered to a sample of Chinese parents of young children for externalizing behavior problems (Leung et al., 2009); therefore, the program again does not address the cultural factors that influence Korean immigrants and their teens. The Incredible Years Parenting Program is a 12-20-week, evidence-based PT series focused on strengthening parenting competencies and fostering parental involvement to address the academic, social, emotional skills, and conduct problems of children ages 3-12 (Webster-Stratton et al., 2011). This program has been previously implemented with Caucasian, African, Hispanic, and Asian American parents (Kim et al., 2008; Lau et al., 2011; Lau & Fung, 2010) with some success (Webster-Stratton, 2009). Specifically, researchers found that while The Incredible Years Parenting Program (without adaptation) significantly increased the use of positive discipline among Korean American mothers, no significant differences were found in social competence and

behavioral problems (Kim et al., 2008). Additionally, the participants reported difficulties with the cultural and linguistic differences (Kim et al., 2010). To address these issues, researchers developed the Korean Parent Training Program (KPTP) which addresses KA child mental health problems, effective parenting strategies, and intergenerational acculturation conflict with the incorporation of Korean cultural values and faith (Kim et al., 2014) Results showed increased effective parenting and decreased child behavior problems (Kim et al., 2014). While promising, the KPTP targets parents of children between 3-8 years old, not adolescents who experience unique developmental changes as well as emotional and behavioral problems (Kim et al., 2014).

Most of the current PT programs are developed for young children, require an extensive time commitment and/or target outcome variables including disciplinary practices, communication, externalizing and internalizing problems, child social skills, and parent-child relationship (Buchanan-Pascall et al., 2018; Dinkmeyer & McKay, 1976; Gordon, 2000; Gordon, 1980; Gross & Grady, 2002; Kim et al., 2014a; Lau & Fung, 2010; Leung et al., 2009; Lochman, 2000; Schuhmann et al., 1998, 1998; Webster-Stratton et al., 2011; Wetterborg et al., 2019; Yap et al., 2016). Lau (2022) provides three indications for adaptations of PTs: 1) differential engagement, 2) differential efficacy/effectiveness, and 3) identified mechanisms of non-response. In controlled trials, immigrant parents were less likely to enroll in PT programs (Cunningham et al., 2000; Reid et al., 2001) and more likely to drop out compared to their White counterparts (Holden, LaVigne, & Cameron, 1990; Kazdin & Whitley, 2003). Additionally, AAs in PT programs had low levels of engagement and were found to have difficulty accepting

Western style parenting techniques such as rewards for compliance and praise for good behavior due to their cultural values (Lau et al., 2011). Filial piety insists that child compliance is an obligation and therefore, does not need positive reinforcement. Due to the lack of engagement and buy-in from AA parents, the effectiveness of the PT programs differ compared to non-minority groups (Kim et al., 2008). Furthermore, it is important to identify and address the mechanisms of non-response to augment the cultural adapted PT (Lau, 2022). Because the skills taught in Western developed PT programs are not culturally native, KAs may limit their participation (Lau, 2022). KAs have specific risk factors that the skills may not address which may prevent improvement (Lau, 2022). Lastly, the standard PT dose may be insufficient for skill acquisition due to unfamiliar skills (Lau, 2022). Based on the examination of the existing PT programs and indications for cultural adaptation, a culturally adapted PT program targeting mental health literacy, stigma, family communication, and attitudes toward seeking services among first-generation KA parents of second-generation teenagers aged 12-18 is needed.

Upon thorough examination of the existing PT programs, we chose Project SHAPE and Stepping Stone to modify through cultural adaptation. Project SHAPE uses a cognitive behavioral based intervention to increase parental comfort and skills in discussing and preventing adolescent behavioral problems (Esposito-Smythers et al., 2017). This family-based prevention program targets alcohol, deliberate self-harm (DSH), and HIV prevention for adolescents in mental healthcare (Esposito-Smythers et al., 2017). One of the main results of the randomized pilot trial designed to test Project SHAPE was that this program was associated with significant improvements in parent

report of parent-child communication around substance use (medium effect), suicide (medium-large effect), and sex (small-medium effects) (Esposito-Smythers et al., 2017). The key component of Project SHAPE's effectiveness is the use of EBI, including psychoeducation, to increase parental comfort and communication skills for addressing uncomfortable, high-risk topics with their teens. Since the main goal of the KFC Program is to provide psychoeducational material that KA parents would accept and trust, we focused on providing culturally competent psychoeducation as the core mechanism of change.

Moreover, to our knowledge, only one PT program exists that targets Korean parents of adolescents. This culturally specific web-based program called "Stepping Stone" is intended to help Korean parents acquire knowledge through psychoeducation, communication, and conflict management skills to address the impact of parent-child relationships in adolescent mental health (Choi, et al., 2016). The program incorporates adolescent development, its impact on parent-child communication, communication skills, psychoeducation on mental health problems, and information on mental health services. While feasible and well-accepted by parents, this intervention was developed specifically for Korean-resident parents of adolescents aged 11 to 16 years old and has only been delivered in Korea. Therefore, we adapted the two existing PT programs, Project SHAPE (Esposito-Smythers et al., 2017) and the Stepping Stone web-based intervention (Choi et al., 2016a), to address the specific needs of KA families.

Adaptation Process

To develop the initial KFC Program manual, researchers examined both Project SHAPE and Stepping Stone to assess components to modify, add, and combine. Following Lau's (2006) selective and directed approach to cultural adaptation, we focused on contextualizing content and enhancing engagement. Contextualizing content involves accommodating the idiosyncratic contextual factors related to the target community's presenting problem though the addition of novel intervention components or alterations to existing intervention content (Lau, 2006). The addition of novel intervention components needs to target group-specific risk processes and mobilize group-specific protective factors (Lau, 2006). Alterations to program content needs to address target symptom presentation patterns that require unique intervention elements (Lau, 2006). Aligned with the directed approach, we used empirical findings on KA cultural experience and barriers to design the cultural adaptation to improve the fit of the EBTs to target first-generation KA parents of second-generation adolescents. We maintained the modular structure, handouts, worksheet exercises, and homework of Project SHAPE and tailored the program modules based on the group-specific symptom presentation patterns. The initial manual added modules on depression, anxiety, eating pathology, and seeking treatment. We altered sections to incorporate Korean cultural values and reduce the program length to increase participant engagement. In the initial manual, modules on substance use, parental monitoring, and risky sexual behavior were removed from Project SHAPE manual based on cultural considerations of the target population. For example, we initially removed those modules, but then added them back

in based on the parent feedback. Researchers also altered the intervention components to address the cultural factors that influence KA adolescent symptom presentation of mental health problems through somatic symptoms and emotional suppression.

Upon examination of Stepping Stone, we incorporated the following relevant topics into the KFC Program manual: adolescent development, parental misconception about adolescence, impact of adolescent development on parent-child communication and relationships, identification of signs, symptoms, and risk factors of common adolescent mental health problems, and differentiation of teen abnormal and normal developmental characteristics (Choi et al., 2016). As discussed previously, a strong ethnic identity buffers against mental health problems among second-generation KA adolescents (Lee & Koeske, 2010); therefore, we focused on mobilizing this protective factor by centering the program on ways KA parents can effectively teach their teens important Korean values through effective communication skills.

Enhancing engagement involves designing adaptations that increase target population engagement without undermining the therapeutic value of the original intervention (Castro et al., 2004). Based on the literature review, family harmony is a cultural value and protective factor that is often disrupted during KA adolescence due to intergenerational acculturation conflict (Crane et al., 2005). Maintaining Korean identity and traditions was related to better mental health outcomes among KAs (Oh, Koeske, & Sales, 2002). To enhance PT engagement, we advertised and highlighted the KFC Program goal as improving family harmony and instilling Korean values/traditions in their teens through EBT techniques. Since the communication skills in Project SHAPE

are developed according to Western values, we also altered the examples to best fit the Korean experience and language dynamics while maintaining the core skills. Furthermore, to address time constraints due to familial and occupational priorities and fear of "losing face" publicly discussing uncomfortable topics (Au, 2017), researchers planned to adapt the manual into a web-based PT program that can be completed at the participant's own pace and home for privacy. Lastly, the program was provided in both English and Korean translations since first-generation KA parents vary in their English proficiency and may prefer to learn in their native language.

Current Study

The purpose of Study 1 was to culturally adapt two existing PT prevention programs (Project SHAPE and Stepping Stone) to develop the KFC Program, a web-based PT program for first-generation KA parents of second-generation adolescents targeting specific cultural barriers to seeking mental health services. As previously discussed, second-generation KA adolescents are a particularly vulnerable population due to the intergenerational acculturation conflict stemming from traditional Confucian values imposed by their first-generation parents. The development and implementation of the KFC Program was critical for these KA teenagers in need of mental health services. The KFC Program focuses on mental health literacy, mental health stigma, family communication, and attitudes towards seeking services. Study 1 aimed to obtain stakeholder feedback on the content, cultural components, acceptability, feasibility, and appropriateness of the KFC Program manual to modify for web-based adaptation.

Hypotheses

We hypothesized that the focus groups and professional consultation in Study 1 would support a need for a culturally adapted PT program for first-generation KA parents of second-generation teens based on intergenerational acculturation conflict. Researchers sought to receive input on factors impacting intergenerational acculturation conflict, recommendations for program recruitment, and suggestions for manual improvement to facilitate piloting of the KFC program in Study 2. We expected the manual modifications to augment participant acceptability and engagement during the pilot phase.

Methods

Participant Recruitment

Participants for the focus groups were recruited via email through the George Mason University Center for Psychological Services, the Washington Multicultural Counseling Center at Washington University of Virginia, the Fairfax County Consortium for Evidence-Based Practice, the Asian American Psychological Association (AAPA) listserv, Healthy Minds Fairfax, The Family Counseling Center of Greater Washington, and the Korean Community Service Center. Inclusion criteria included English-speaking, first-generation KA parents of second-generation children aged 12-25. Although the program is intended for parents of 12–18-year-olds, those with children between 19-25 years old can still provide valuable information having recently parented a teenager. Of note, researchers reached out to thousands of people through the organization listservs and only recruited 7 to participate in the focus groups. Additionally, a licensed KA therapist was recruited through the AAPA listserv to provide professional consultation of

the KFC Program manual. Focus group participants were compensated with a $75 Visa e-gift card after participation of each focus group ($150 total). They were partially compensated if they decided to participate in only the first focus group session. The professional consultant was compensated $100 per hour (3 hours max) for her services.

Procedures

To develop the initial KFC Program manual, researchers modified Project SHAPE and Stepping Stone based on the adaptation process described above. After approval from the Institutional Review Board, KA parents were recruited to participate in the study. Participants completed verbal and written consent via phone and Qualtrics, an online survey tool. Prior to the focus group, participants were instructed to review the initial KFC Program manual and program measures as well as complete a set of questionnaires to assess the acceptability, appropriateness, feasibility of the program. During the virtual focus group on WebEx, participants were led in guided discussion to receive feedback and reactions to the manual, the program structure, recommendations for recruitment, suggestions for improvement, and views on the cultural aspects of the manual. See Appendix for the focus group guide. Following the focus group, individuals were compensated for their participation.

To gain additional insight, researchers connected with a licensed KA therapist for a professional consultation on the initial KFC Program manual and focus group feedback. The consultant reviewed the manual and provided feedback via WebEx. After the meeting, she was compensated for her consultation services. Feedback from the first focus group and the consultation were compiled and used to improve the manual. The

focus group participants were instructed to review the revised manual and complete a set of questionnaires. The final focus group was held on Zoom due to administrative changes. The final focus group followed the same procedure as the previous one. Individuals were compensated following the session. Final revisions were made to the manual based on participant feedback. Afterwards, the revised manual was adapted into a web-based program using the Canvas Platform.

Measures

Acceptability of Intervention Measure (AIM)

The AIM (Weiner et al., 2017) is 4-item questionnaire on perceived intervention acceptability. For example, "The intervention meets my approval." The measure is rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). An average is calculated, and higher scores indicate greater acceptability. The AIM demonstrated good internal consistency ($\alpha = 0.89$) and test-retest reliability ($r = 0.83$) (Weiner et al., 2017).

Intervention Appropriateness Measure (IAM)

The IAM (Weiner et al., 2017) is 4-item measure of perceived intervention appropriateness. For example, "The intervention seems fitting." The measure is rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). An average is calculated, and higher scores indicate greater appropriateness. The AIM demonstrated good internal consistency ($\alpha = 0.87$) and test-retest reliability ($r = 0.87$) (Weiner et al., 2017).

Feasibility of Intervention Measure (FIM)

The FIM (Weiner et al., 2017) is a 4-item instrument to assess perceived intervention feasibility. For example, “The intervention seems implementable.” The measure is rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). An average is calculated, and higher scores indicate greater feasibility. The FIM demonstrated good internal consistency ($\alpha = 0.89$) and test-retest reliability ($r = 0.88$) (Weiner et al., 2017).

Data Collection & Analyses

The interviewer wrote detailed notes of the discussion during the video-recorded focus group sessions. The senior author and a research assistant individually took notes of the video-recordings to compare themes for analysis. Prior to both focus group sessions, the participants completed online measures on intervention acceptability, appropriateness, and feasibility of the initial and revised KFC Program manual. Participants were also given the option of anonymously answering the discussion questions via Qualtrics.

Data were analyzed using thematic analysis, a method of identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006). Thematic analysis involves six steps: 1) familiarizing oneself with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report (Braun & Clarke, 2006). Using both a deductive and inductive approach, data was coded for previously identified cultural factors impacting IAC within KA parent-child relationships as well as new themes from the discussion. Data were also coded for participant suggestions for manual improvement and program recruitment. Utilizing the latent level approach, researchers coded the data for underlying ideas, assumptions, and

ideologies theorized for shaping the semantic content of the data (Braun & Clarke, 2006). Interviewer notes were typed and reviewed by the research team. Two research members independently watched the video-recordings of the focus group sessions and typed notes to familiarize themselves with the data. In a systematic fashion, an initial list of codes was generated and collated. The collated codes were sorted into previously identified and emergent themes. The research team (i.e., first author, senior author, and research assistant) reviewed, refined, and named the themes, then determined how to incorporate the themes into the revised manual.

To analyze the measures assessing intervention appropriateness, acceptability, and feasibility, we calculated the mean of each measure item as well as the grand mean to compare scores from the initial and revised KFC Program manual.

Results

Participants

Seven first-generation KA parents of second-generation children ages 12-25 (6 mothers, 1 father) participated in the first focus group to discuss the initial KFC Program manual. Sociodemographic information about the focus group participants was not collected to maintain the anonymity to facilitate open communication without fear of "losing face." The first focus group was split into two groups of four and three participants due to scheduling difficulties. Five mothers returned to provide feedback on the revised manual. Four members joined a second focus group videoconferencing. One participant was unable to join the scheduled focus group due to scheduling confusion, so the participant took the option to respond to the focus group guide questions through

Qualtrics to still provide feedback. The remaining two participants reported their inability to participate due to their busy schedules.

Themes

The main and subthemes were identified and grouped by the study aims: cultural factors impacting IAC within KA parent-child relationships, suggestions for manual improvement, and recommendations for program recruitment. As the same themes emerged from both focus groups, the findings were collapsed for simplicity. Table 1 summarizes emergent themes from focus group 1 and 2.

Table 1: Emergent Themes

Emergent Themes from Focus Groups with KA Parents

Cultural Factors Impacting IAC	Examples
Filial Piety	▪ Perceived KA adolescent attitude ▪ Expectation of obedience
Communication Language	▪ Communication tied to culture ▪ Desire to understand each other ▪ Practical issues with implementing communication skills ▪ Lack of direct Korean to English translations ▪ Miscommunication due to language differences
Perception of Korean Values	▪ KA adolescent negative view of Korean values ▪ Stoicism as a virtue ▪ Academic pressure ▪ Generational parenting

Misconceptions about Mental Health	▪ Mental health not life threatening ▪ Assumptions of mental health in boys
Mental Health Stigma	▪ KA parents lack of understanding mental health issues ▪ Discomfort discussing mental health and high-risk behaviors in front of other KA parents
Suggestions for Manual Improvement	**Examples**
Provide More Information/Education to Help their Children	▪ Include references and more research citations ▪ Include more research about mental health among boys ▪ Include topics about social media use, substance use, and sexual behavior ▪ Include information on affordable services
Cultural Specificity	▪ Incorporate specific Korean values ▪ Revise vignettes to be more Korean specific
Recommendations for Program Recruitment	**Examples**
Korean Communities	• Korean churches • Korean schools • School liaisons
Importance of Status	• Highlight program developed by university

Cultural Factors Impacting IAC

In the focus group sessions, participants identified the cultural differences creating conflict within their intergenerational KA families. The following themes

emerged as factors that need to be addressed, so KA parents are more willing to seek the mental health services their adolescents may need.

Theme #1: Filial Piety

The cultural expectation of filial piety, the attitude of obedience and respect for one's parents and elders, emerged as a main theme. One KA parent reported conflict due to Americanized teenagers talking back, perceiving the children's response as disrespectful: "If they talk back, I don't like it. Usually, parents get mad because of their attitude and then they get confused. We don't focus on feelings first, we get mad." Western values of assertive communication and expressing one's opinion is valued at school; however, when second-generation KA adolescents apply these at home to their traditional parents, they are often reprimanded for their lack of filial piety and viewed as disobedient children.

Theme #2: Communication

Additionally, communication differences emerged as another factor contributing to the IAC within KA families. The parents expressed how culture impacts communication, which makes it difficult to change and leads to miscommunication: "They (KA adolescents) think it's too straight. That we are angry already, but we are not." Because the Korean parenting style lacks verbal affection and Westernized pleasantries, KA adolescents believe their parents are angry when, in fact, the bluntness is just a cultural norm. When discussing the validation skills taught in the program manual, another parent stated, "The Korean way of communicating, we don't talk that way." This sentiment was supported by a participant who reported, "We are not used to

communicating this way." While the KA parents voiced frustration with the communication differences, they expressed a strong desire to improve communication for mutual understanding: "We want to understand them and they understand us." Another parent stated, "If we can get a glance into what our kids our thinking these days, it'll help us communicate with them better" and "It's hard to know how to respond to this kind of behavior (substance use, risky sexual behavior). I want to learn how and what's the norm." When discussing the communication skills described in the manual, parents conveyed concern about practical implementation: "It's too difficult to use that kind of language," "We know we need to touch their emotions but how," and "It's difficult for us to do that quickly – I've got to touch their emotion first, so I have to stop and think about this. How can relate to their emotional but in a way that I can do that in a way that Koreans speak." Moreover, a parent discussed how Korean culture impacts communication based on gender: "Korean culture, we really force masculinity for boys – especially for the first son of the family. I really want to support their emotions… but typically boys are not good at expressing their feelings… because of "manhood."

A subtheme that emerged was Korean language and its impact on communication. While American communication relies more of the actual words exchanged to convey ideas and messages, Korean communication tends to be situation/context-based and focused on the subtle ability to listen and sense what people are thinking and feeling (Kim, 1985). Because of this difference, KA parents assume that their children will understand what they are saying based on the context of the situation; however, KA adolescents often take offense to their parents' words because they are not as familiar

with communicating in a context-based manner: “I think I communicate well with them, but then sometimes they get so upset over what I said to them, but that’s not what I meant to them in the first place and they took it the wrong way and then we focus on their attitude and we fight with them.” Additionally, accurate communication often gets lost in translation due to the lack of direct Korean to English translation: “As a first-generation parent, I talk to them like a Korean parent. Even though I speak English to my kids, there is a lot of misunderstanding when I talk to them. I didn’t mean that, but they take a word in a way I don’t mean.” Furthermore, another parent commented on the complexity of the Korean language: “Korean culture is very complicated. It depends on how a person comprehends the word. There is a lot of meaning included.” Korean words hold significant meaning and nuance and the lack of direct Korean to English translation makes it difficult for KA parents to communicate exactly what they mean.

Theme #3: Perception of Korean Values

Aligned with previous research about IAC factors impacting KA parent-child relationships, the parents discussed how the differing perceptions of Korean values create conflict within their families. One parent conveyed how KA adolescents view the value of stoicism, a virtue in Korean culture: “If a person doesn’t know Korean culture deeply, then a person may have a negative impression of Korean tradition […] Korean culture conflicts with emotional free expression. That kind of Korean tradition is a virtue in Korean culture, but this is negative in American culture. That kind of attitude in Korean culture is not bad or evil […] Some parts of Korean culture is a virtue traditionally, but with Americanized children, it is conflicting with their school and create conflict between

parents and children." Along with stoicism, the value of education contributes to discord at home. One parent suggested adding an example of parent-child conflict about academic stress: "Add example about parent child conflict about academic stress […] first generations have academic pressure. My boys are more likely to say, 'White families are the coolest and they don't have this pressure.'" As immigrants, KA parents push their children to excel in academics, so their children can succeed in a foreign country. Another parent highlighted how KA parents learn from generational parenting and their good intentions are often misinterpreted by their adolescents: "You learn from your parents and parents' parents - good morals from parents' generation […] Korean parents have good intentions, but there is misunderstanding – don't want to give the impression that traditional things are so oppressive for young people, but this is not always true." The KA parents expressed the desire to teach their children Korean values in an effective way.

Theme #4: Misconceptions about Mental Health

During the focus groups, the KA parents' made comments that highlighted misconceptions about mental health common among this population. One participant shared that she attempted to find a therapist for her child but had difficulty finding the right fit and stopped since "it is not a life-threatening matter." A parent also noted that "Parents who really need the help are not interested in this kind of program." Mental health is commonly viewed as trivial, particularly due to Korean culture prioritizing somatic, medical issues. Furthermore, misconceptions about gender differences in mental health emerged: "The topics are more suitable for girls. Some topics are not relevant to

parents of boys." Participants believed that depression, anxiety, and eating pathology were not issues that applied to boys. This is particularly relevant to the cultural expectation of masculinity as demonstrated by emotional suppression.

Theme #5: Mental Health Stigma

The participants acknowledged the stigma around mental health topics that impede parents' ability to learn about these issues and support their teens. One KA parent reported, "You included topics like depression and anxiety and things like that. That could be difficult for parents to understand about what depression is about. So, it's great that you break down each item of what the teenager may experience." The participants appreciated that the program was online due to the discomfort of discussing mental health and high-risk behaviors publicly: "Since this is a paper that parents can read – so we need as much information as possible, so we don't have to ask somebody face to face. Include as much information as you can." Another parent shared that "when we have to see each other which is very uncomfortable, but if we can just read it, it doesn't matter." In Korean culture, mental health topics are only to be discussed within the family in order to "save face."

Suggestions for Manual Improvement

Participants provided suggestions to improve the content of the initial manual.

Theme #1: Provide More Information/Education to Help their Children

When discussing ways to improve the manual, the suggestions made by the KA parents demonstrated how the cultural importance of education continues through adulthood. One parent shared, "I realized I stopped reading parenting books when my

boys went to middle school. Instead, I read articles about academics and college admission – it was very self-reflective." They expressed interest in the inclusion of more research citations and references, so they can educate themselves on the studies: "I want to see more citations/references. What year? What kind of statistics? What sources? I appreciate research based, but for personal curiosity, I want to see the references." Another parent echoed the sentiment stating, "I hope you can provide the numbers – how many … Korean kids and comparing to other groups." They also suggested incorporating research on the gender differences for these mental health issues. The participants expressed interest in additional topics of substance use and sexual behavior: "This topic is very extreme behavior being raised in Korea – so it would be helpful to have the early signs and identification – when you figure out your child is in danger, how do you respond? I don't know how to do it" and "Safe sex, that's necessary." The parents also sought information about ways to navigate social media and cell phone use with their teens: "I still have lots of questions about cell phones and social media. Is there any relation between cell phones and mental health and the amount of time they spend?" Lastly, the participants asked for information on finding affordable mental health services.

Theme #2: Cultural Specificity

The main recommendation for the manual was greater cultural specificity. Regarding the initial manual, a few parents noted, "It's very general and not Korean specific – is there more research about how Korean traditions affect Korean teens mentality?" and "It's very general, I almost forgot it's focused on Korean parent." The

participants also provided feedback on the communication vignettes, suggesting the incorporation of more cultural-based conversational phrases to make them more relevant and relatable. The parents highlighted the importance of integrating Korean values into the program: “This has to have the cultural aspects really deep into it so, when people see it, they know ‘This is for Koreans.’ This information is very useful, but I don’t see a lot of Korean culture” and “Information like this is out there – as a Korean parent I’m looking for something that can help me understand my teen – there is always some difference that I can’t catch up with them.”

After revision of the initial manual, the participants commented that Korean values were well-incorporated throughout. Parents made the following remarks: “You added more cultural sensitive terms and cultural pieces- you nailed it” and “Good you mentioned Korean culture in the sexual education section.” The participants also assisted in identifying the correct Korean phrases to describe certain values: “Koreans are also famous for perseverance and diligence – tenacity is not quite right” and “Maybe willpower – you are going to complete this, you are going to finish this no matter what.”

Recommendations for Program Recruitment

Focus group participants provided recommendations for the pilot study recruitment.

Theme #1: Korean Communities

To recruit for the pilot study, the participants suggested reaching out to Korean community hubs, including Korean churches and Korean language schools. They also recommended connecting with Korean parent school liaisons to assist with recruitment.

Theme #2: Importance of Status

To increase buy-in, the participants recommended promoting that the program was provided by a large-scale organization (i.e., George Mason University) for credibility.

Quantitive Results of AIM, IAM, FIM Measures

Results from the AIM, IAM, and FIM measures showed an increase in acceptability, appropriateness, and feasibility scores of the KFC Program from focus group 1 to focus group 2. See Table 2 below for details.

Table 2: Focus Group AIM, IAM, and FIM Outcomes

Means of Intervention Acceptability, Appropriateness, and Feasibility Scores of Focus Groups 1 and 2

Measure Item	Focus Group 1 *M*	Focus Group 2 *M*
Acceptability of Intervention Measure (AIM)		
1. The Korean Family Communications Program meets my approval.	3.7	4.2
2. The Korean Family Communications Program is appealing to me.	3.6	4
3. I like The Korean Family Communications Program.	3.4	4
4. I welcome The Korean Family Communications Program.	3.7	4
AIM Grand Mean	3.6	4
Intervention Appropriateness Measure (IAM)		

1. The Korean Family Communications Program seems fitting.	3.7	3.8
2. The Korean Family Communications Program seems suitable.	3.7	3.8
3. The Korean Family Communications Program seems applicable.	3.7	3.7
4. The Korean Family Communications Program seems like a good match.	3.1	3.8
IAM Grand Mean	3.5	3.8
Feasibility of Intervention Measure (FIM)		
1. The Korean Family Communications Program seems implementable.	3.9	4.2
2. The Korean Family Communications Program seems possible.	3.7	4.2
3. The Korean Family Communications Program seems doable.	3.6	4.2
4. The Korean Family Communications Program seems easy to use.	3	3.8
FIM Grand Mean	3.5	4.1

Results from Professional Consultation

A licensed KA psychologist provided consultation on the initial KFC manual and the focus group feedback. The consultant helped the researchers identify the specific Korean values to incorporate throughout the manual, including harmony, tenacity, filial piety, disciplined behavior, deep sense of love and loyalty, adaptability, perseverance,

and education. Based on the focus group feedback, the consultant recommended framing the program from a strengths-based model to increase buy in and highlight the benefits of instilling Korean values in the second-generation.

Discussion

Second-generation KA adolescents are a particularly vulnerable population due to the IAC within their families (Lui, 2015). A culturally adapted PT prevention program for first-generation KA parents is needed to address the following factors impeding KA teenagers from receiving the mental health services they need: mental health literacy, mental health stigma, attitudes toward seeking services, and parent-child communication. Despite the literature on IAC factors contributing to the development of KA psychopathology and resistance to help-seeking (Hwang & Wood, 2009; Tsai & Yeh, 2011), the existing culturally adapted PT programs fail to specifically target the cultural barriers hindering KA adolescents from receiving appropriate care. Therefore, the present study aimed to fill this gap in the KA mental health literature.

This study is not only the first to culturally adapt a PT for KA parents of adolescents targeting cultural barriers, but also use an extensively iterative adaptation process to develop the program. Based on the literature, we found that specific Korean cultural values negatively impact first-generation parents' willingness to pursue mental health services for their adolescents (Lui, 2015). Therefore, the KFC Program purposefully addressed these values of collectivism, "saving face," mind-body holism, and willpower. Additionally, to our knowledge, only one PT program targets adolescents

of this cultural group (Choi et al., 2016) and it was developed for Korean residents, which does not account for the KA adolescent experience. Thus, the KFC Program addressed this gap by incorporating general adolescent development as well as the unique KA teen experience. Furthermore, we used an extensive iterative adaptation process to develop the KFC Program manual. Based on the literature review, we created an initial KFC Program manual by adapting two existing PT programs, Project SHAPE and Stepping Stone. After KA parents reviewed the manual, the KFC Program was revised based on feedback from focus group 1 and a professional consultation. Following the first round of revisions, the KA parents provided further feedback in focus group 2. The second round of revisions resulted in the final version of the KFC Program manual. The extensive iterative adaptation process of the present study is a significant strength.

Results from the focus groups yielded themes we used to modify the KFC Program manual. Five themes emerged related to the cultural factors impacting IAC: filial piety, communication, perception of Korean values, misconceptions about mental health, and stigma. Regarding suggestions for manual improvement, two themes surfaced about providing more information/education to help their children and greater cultural specificity of the manual. Lastly, two main themes arose when discussing recommendations for program recruitment: Korean communities and the importance of status.

The emergent themes for cultural factors impacting IAC aligned with previous research. The expectation of filial piety conflicts with the Western value of assertive communication that second-generation KA adolescents learn outside the home (Kim &

Hong, 2007). KA parents view any verbal response other than absolute agreement as disobedience and disrespect. While KA adolescents respect their parents, their expression of filial piety clashes with traditional standards. To address this issue, the KFC Program manual provides psychoeducation on this cultural difference and ways to navigate it using EBT techniques.

Due to the differences in Korean and Western parenting styles, KA adolescents view the blunt way their parents communicate as harsh and cold rather than a cultural norm. Along with the cultural differences in parenting, the context-based Korean language poses an additional issue due to the lack of direct Korean to English translations of some phrases, resulting in miscommunication and further family conflict. The focus group participants also expressed how certain communication skills, such as validation, are particularly challenging for KA parents because they differ from how typical Korean parents speak to their children. While they acknowledged the difficulties of the communication differences, the parents conveyed a strong desire to improve communication to better their relationship. Therefore, the KFC Program provided communication skills adapted for KA parents.

Consistent with the literature, the perceptual difference of Korean values creates conflict within KA families. For example, KA adolescents view stoicism and academic expectations as oppressive whereas first-generation KA parents perceive these as virtues passed down from generational parenting. The participants expressed frustration that their good intentions are often misinterpreted and hoped to instill Korean values in their teens. Previous research has found that maintaining Korean identity and traditions were related

to better mental health outcomes and moderated IAC among KAs (Lee & Koeske, 2010; Oh, Koeske, & Sales, 2002). Thus, the KFC Program focused on mobilizing this protective factor by educating KA parents on how to instill Korean values in their adolescents in an effective way.

Moreover, the theme of misconceptions about mental health emerged during the focus groups. The KA parents discounted mental health as a non-life-threatening issue that does not need to be prioritized, especially compared to physical health concerns. Aligned with cultural toxic masculinity, the participants shared inaccurate assumptions of the gender differences in mental health disorders, stating that the topics of depression, anxiety, and eating pathology are irrelevant to boys. Consequently, one of the main outcome variables of the KFC Program is mental health literacy, debunking myths and providing psychoeducation.

Furthermore, the theme of mental health stigma emerged as KA parents reported a general lack of understanding of mental health issues as well as discomfort discussing these topics publicly. Consistent with previous research on "saving face," topics about mental health and high-risk behaviors are only to be discussed within the family behind closed doors (Ho, 1984). Because openly discussing these topics has grown to be more widely accepted in Western culture, KA adolescents are more familiar and comfortable with talking about mental health, a taboo in Korean culture. The difference in knowledge and approach to navigating psychological issues creates another area of conflict between KA adolescents and their parents. Additionally, this need to "save face" due to perceived stigma creates a barrier for KA parents to seek out psychoeducation and mental health

services for their teens. With consideration of this cultural issue, the KFC Program is provided on a web-based platform, so parents can receive the necessary psychoeducation while "saving face." The KFC Program addresses mental health stigma, through psychoeducation, which research has found to significantly decrease stigma, improve empowerment during crises, and increase coping skills among KAs (Shin, 2004).

Regarding manual improvement, the participants suggested more information/education to help their children and greater cultural specificity. They requested more research citations and references, so they can educate themselves on the specific studies. The KA parents also suggested additional modules about sexual behavior, substance use, and social media use as well as information about affordable services. While the participants reported that the initial manual was helpful, they expressed the need for greater specificity of Korean culture in the program with the incorporation of Korean values and culturally-tailored examples. With the assistance of a professional consultant, the manual was successfully revised based on the feedback.

For program recruitment, the KA parents recommended connecting with Korean communities through Korean churches, Korean language schools, and Korean parent school liaisons. Research has found that 70-85% of KAs regularly attend KA churches (Kwon, 2004), making the churches cultural hubs for the community. Additionally, Korean language schools are organized and operated within Korean churches with at least 1,200 Korean language schools in the United States (Lee & Shin, 2008). Korean churches help KA children maintain their heritage language and culture through these educational programs (Min, 2000; Shin, 2005). Often due to language barriers, KA parents struggle to

be involved with their children's school, so Korean parent school liaisons in districts with high KA populations (i.e., Fairfax County Public Schools) facilitate these connections. The participants also suggested that researchers highlight that a large-scale organization (i.e., George Mason University) developed the program to enhance credibility and buy-in. Researchers planned to recruit for the pilot study through these avenues.

Results from the AIM, IAM, and FIM indicate the following: After review of the initial KFC Program manual, participants rated an average of 3.6, 3.5, and 3.5 on the AIM, IAM, and FIM, respectively. These scores of acceptability, appropriateness, and feasibility of the program fell between "neither agree nor disagree" and "agree." After revisions, the participants rated an average of 4 and 4.1 on the AIM and FIM, indicating that they agreed that the program was acceptable and feasible. On the IAM, participants rated an average of 3.8, a .3 increase from the initial manual review. Overall, the results from the AIM, IAM, and FIM showed that the intervention acceptability, appropriateness, and feasibility increased after making revisions based on the focus group feedback.

Limitations

Although this study had many strengths, including its theory-driven, iterative adaptation process and emphasis on stakeholder involvement, several limitations should also be noted. Despite the researchers' extensive recruitment efforts through various community contacts across the country, only 11 people of the thousands contacted expressed interest in participating in the focus groups. Among those 11 individuals, seven participated in focus group 1 and five returned for focus group 2. The present study's

recruitment process was consistent with previous research also detailing the difficulty with research recruitment among the KA population due to cultural values about mental health, language barriers, lack of awareness about research studies, and lifestyle priorities (Han et al., 2007). In particular, the study's recruitment challenges relate to the cultural stigma against talking about mental health with people outside of the family due to the potential loss of face. To prepare to recruitment of the pilot study, researchers specifically requested recommendations for recruitment.

Additionally, the participants self-selected based on their interest and investment in improving relationships with their teens. As one participant stated during the focus group, "Parents in this meeting are eager to help their children, they are not the ones who need this program's help. Parents who really need the help are not interested in this kind of program." While the focus group comments were helpful, the feedback was provided from the perspective of KA parents who may already have lower levels of mental health stigma and actively work on their relationships with their children, making them more willing to seek mental health services for their teens. During the pilot study, researchers attempted to address this issue by advertising the program without using mental health-related words and focusing on the promotion of Korean cultural values.

Conclusions & Future Directions

The current study provided insight into the cultural adaptation of a PT prevention program for first-generation KA parents of second-generation adolescents. Gathered from stakeholders, the qualitative data revealed key themes (i.e., filial piety, communication, perception of Korean values, misconceptions about mental health, and stigma) necessary

to address in PT programs for the KA population. Cultural specificity through the incorporation of values should be emphasized in future cultural adaptations.

STUDY 2. CULTURAL ADAPTATION OF A PREVENTION PROGRAM FOR KOREAN AMERICAN PARENTS OF ADOLESCENTS: A PILOT STUDY

With the highest prevalence of mental disorders compared to other Asian American (AA) groups, second-generation Korean American (KA) adolescents are at increased risk of developing mental health disorders (Burt et al., 2003; Hochgraf et al., 2017; Lui, 2015; Marmorstein & Iacono, 2004; Nguyen et al., 2018; Yasui et al., 2018)**.** Despite this elevated risk, KA adolescents have low rates of help-seeking behavior due to the cultural barriers caused by intergenerational acculturation conflict (IAC) in their families (Abe-Kim et al., 2007; Au 2017; Cheung 2011). Specifically, the cultural values of collectivism, "saving face," mind-body holism, and willpower lead to barriers that hinder first-generation KA parents from seeking mental health services for their second-generation KA adolescents (Jeong et al., 2018). While previous research has examined these cultural values that influence reluctance to seeking services (i.e., mental health stigma, mental health literacy, attitudes towards help-seeking, and family communication) (Au, 2017; Jeong et al., 2018). there are no existing culturally adapted parent training (PT) prevention programs designed to target these barriers within the KA population.

To address to this need, this study aimed to describe the Korean Family Communications (KFC) Program, the cultural adapted PT prevention program for first-generation KA parents of second-generation adolescents and pilot the web-based program in a sample of KA parents. First, we will provide a brief overview of the development of the KFC Program (Study 1), then describe program considerations for the pilot trial. Afterward, an overview of the program's core mechanism of change and descriptions of the modules will be provided. Lastly, we will present the procedures and results of the pilot trial of the KFC Program.

Development of the KFC Program

To develop the KFC Program, researchers used Lau's (2006) data driven adaptation framework to inform cultural adaptation to the systematic process of assessment, preparation, and implementation posed by McKleroy et al. (2006) and Movsisyan et al. (2019). Based on the literature, we created the initial manual by contextualizing content from two existing PT programs, Project SHAPE (Esposito-Smythers et al., 2017) and Stepping Stone (Choi et al., 2016a), and incorporating elements to enhance engagement (Lau, 2006). Revisions to the manual were made from two rounds of stakeholder (first-generation KA parents and licensed KA psychologist) focus group sessions. From the stakeholder feedback, several themes emerged regarding cultural factors impacting IAC, suggestions for manual improvement, and recommendations for program recruitment (See Study 1). Following final revisions, the manual was adapted into a web-based program using the Canvas Platform.

Program Considerations

Based on the KA mental health literature and stakeholder feedback, certain program factors needed to be considered to ensure its success, including modality and recruitment concerns. When considering the most effective program modality, the cultural value of "saving face" was regarded as a potential barrier to KA parents participating in an in-person program as attending a training to address topics such as family communication and mental health may suggest disruption in the family. The potential to "lose face" by publicly discussing these issues might outweigh the parents' interest in learning ways to improve their parent-adolescent relationships. In the initial KFC Program manual, the modules for substance use and sexual behavior were removed based on the conservative culture of the ethnic group. However, the focus group participants requested information about these culturally taboo topics when it was understood that the KFC Program would be online and not in-person. The stakeholder response solidified our decision to provide the program online.

Furthermore, researchers needed to consider recruitment challenges with this "hard-to-reach" population. Previous research has found that cultural beliefs about mental health, language barriers, lack of awareness about research studies, and lifestyle priorities result in difficulties recruiting KAs (Han et al., 2007). With potential recruitment challenges in mind, the researchers intentionally asked the stakeholders for recommendations, which included research-indicated Korean community hubs: Korean churches and Korean language schools. Additionally, previous studies found that language is a significant barrier to study recruitment and results in poorer program

outcomes for KAs (Han et al., 2007; Kim et al., 2008, 2010). To address the language barrier, the KFC Program was provided in both English and Korean as first-generation KAs vary in their English proficiency. Moreover, based on stakeholder feedback, we tailored our program approach to a strengths-based model, aligning with KA parents about the strengths of Korean values and educating them on how to effectively instill these traditions in their adolescents. This approach is consistent with research finding that ethnic identity is a protective factor for KA adolescents (Lee & Koeske, 2010) and the need for cultural adaptations to mobilize protective factors (Lau, 2022).

Core Mechanism of Change

Based on the literature review and stakeholder feedback, the KFC Program focused on providing culturally competent psychoeducation as the core mechanism of change. The positive response from participants during focus group 2 (after manual revision) highlighted the importance of providing culturally competent information to increase participant receptiveness. A main goal of the current study was to develop psychoeducational material that KA parents would accept and trust. This was done by culturally adapting the information and underscoring the strengths of Korean values. Additionally, psychoeducational interventions for KAs were found to significantly decrease stigma, improve empowerment during crises, and increase coping skills (Shin, 2004). Therefore, we used culturally competent psychoeducation as the core mechanism of change to target the study's goals of increasing mental health literacy, decreasing stigma, strengthening parent-child communication, and improving attitudes towards seeking mental health services.

Culturally Adapted Parent Training Prevention Program

The KFC Program is a culturally adapted PT prevention program for first-generation KA parents of second-generation adolescents targeting mental health literacy, stigma, parent-child communication, and attitudes towards seeking services. The web-based program includes didactic video presentations (verbal persuasion), assignments (enactive attainment), and handouts (resources). Provided in English and Korean, the eleven modules cover the following topics: 1) Bicultural Identity and Parenting Styles, 2) Positive Parenting, 3) Family Communication, 4) Depression and Suicide, 5) Anxiety, 6) Eating Problems, 7) Substance Use, 8) Sexual Behavior, 9) Social Media Use, 10) Emotion Management, and 11) Seeking Treatment. Recommendations for the program suggested completing modules 1-3 on day 1, modules 4-6 on day 2, 7-9 on day 3, and 10-11 on day 4; however, the self-paced program allowed participants to complete the 4.5-hour program in their preferred order and speed. The KFC Program begins with an introduction video about the program and how to navigate the Canvas platform. Of note, each module cites culturally relevant research on the respective topic. A list of references is provided at the end of each module. The program modules are described below.

Module 1: Bicultural Identity and Parenting Styles

The Bicultural Identity and Parenting Styles module provides information on bicultural identity, the strengths of Korean and American culture, and the four parenting styles. The voice-recorded video presentation begins with discussing the benefits of biculturalism and relating it to the Korean value of adaptability. To help parents identify the strengths of Korean and American culture, the participants are instructed to complete

the “Bicultural Values” worksheet, which directs them to reflect on the parts of Korean and American culture they value and want to teach their teens. The next video explains the four different parenting styles (authoritative, authoritarian, permissive, and uninvolved) and how each affect adolescent development, highlighting the benefits of authoritative parenting. Participants are then instructed to complete the “Parenting Through the Generations” worksheet to reflect on the values their parents taught them and what values to keep or change with their own children.

Module 2: Positive Parenting

The Positive Parenting module provides information on the importance of attending to positive teen behavior, how to effectively praise teens, and empathetic listening and validation skills. The video presentation begins with explaining the rationale for catching positive behaviors and how this parenting technique encourages the Korean values of tenacity and adaptability in their adolescents by attending to them. The video continues with reviewing guidelines for effective praise. Afterwards, the parents are instructed to complete the “Attending to Positive Behaviors” worksheet to help them identify teen behaviors they can praise. Then, the video provides the rationale for validating teen emotions and how the skill relates to the Korean value of the deep sense of love and loyalty. The program normalizes the initial discomfort of communicating in this new way for KA parents. Parents learn the steps for empathetic listening and validation and practice by completing the “Practice Examples” worksheet. The worksheet instructs parents to identify the teen’s emotion based on brief scenarios and then write an appropriate response using empathy and validation. For homework, parents are assigned

to praise their teen at least two times a day and pay attention to their reactions as well as practicing empathetic listening and validations skills during the week.

Module 3: Family Communication

The Family Communication module provides information on adolescent development, its effect on family communication, effective communication skills, and the cultural differences in expression of affection. The video begins by explaining the cognitive, social, and emotional changes occurring during adolescent development and how to navigate these changes to effectively instill the Korean values of disciplined behavior and filial piety. The module also highlights the cultural difference in emotional expression. While American communication relies more of the actual words exchanged to convey ideas and messages, Korean communication tends to be focused on the subtle ability to listen and sense what people are thinking and feeling. Acknowledging the different ways KA adolescents and their parents communicate, the module encourages the use of effective communication skills to lessen the gap. After these skills are reviewed, the module explains the cultural differences in emotional expression and ways to combine the two. For homework, parents are assigned to practice the effective communication skills and show affection by combining the Korean and American ways.

Module 4: Depression and Suicide

The Depression and Suicide module informs parents about depression and suicide, common myths, the difference between clinical depression and typical teenage emotions, and steps to address depression and suicidal behavior. The video presentation describes depression among KA adolescents and how the cultural focus on somatic

symptoms influences its presentation in this population. Information on the symptoms and causes of depression are provided. The module also reviews the common misconceptions about depression and explains the difference between clinical depression and typical teenage emotion, so KA parents can more accurately identify the symptoms in their adolescents. Furthermore, the module provides psychoeducation on suicide: debunking myths about suicide among teens, discussing warning signs, and explaining steps to address suicidal risk. The module encourages using the communication skills from Module 3 to express the Korean value of love and loyalty and maintain their teen's safety during these situations. Handouts for depression and warning signs for suicide are provided.

Module 5: Anxiety

The Anxiety module informs parents about anxiety, the difference between typical worries and clinical anxiety, and steps to address anxiety in their teens. The video begins by describing the symptoms and causes of anxiety as well as the consequences of untreated anxiety on adolescents. The module also provides research on the presentation of anxiety among KA adolescents. Additionally, the difference between clinical anxiety and typical teen worries are detailed along with the types of treatment for anxiety. The module also discusses using the effective communication skills to support and help their teens receive the appropriate treatment. A handout about anxiety is provided.

Module 6: Eating Problems

The Eating Problems module provided psychoeducation on eating pathology, risk factors specific to KA teens, steps to address eating disorder (ED) behaviors, and the

types of treatment. The video explains the research on the development of EDs among KA adolescents due to acculturative stress and cultural "lookism," prejudice or discrimination based on physical appearance that is less than societal beauty standards. The module also spotlighted common weight management behaviors among Koreans that are deemed normal but can cause serious physical and mental health issues. Information about the physical development during adolescence provides background into the normal body changes teen girls and boys experience. After defining normal eating, the video proceeds to define the different types of EDs and warning signs. The module concludes with ways to approach teens about EDs, referring back to the effective communication skills, and the types of ED treatment available. Handouts about the types of EDs and warning signs are provided.

Module 7: Substance Use

The Substance Use module informs parents about alcohol and drug use, their negative effects, risk factors and signs of use, and how to talk to teens about substance use. The video describes the research on substance use among KA adolescents, focusing primarily on alcohol, marijuana, and cigarettes as they are the most common substances used by KA teens. Furthermore, the module identifies specific risk factors and predictors of substance use for this population, so parents can be aware for their own teens. The parents are instructed to read the "Alcohol and Drug Use Fact Sheet" to learn about the negative effects of alcohol, cigarettes, and marijuana. The video continues with information on the signs of intoxication and recent drug use. Then, parents complete the "Values on Substance Use" worksheet, so they can reflect on their own values around

substance use and determine what to teach their teens. The module resumes with how to talk to teens about drugs and alcohol. Handouts about substances, signs of intoxication and recent drug use, and tips for talking to teens about substance use are provided.

Module 8: Sexual Behavior

The Sexual Behavior module provides psychoeducation on sexual behavior among AA teens, sexually transmitted diseases (STDs) and HIV/AIDS, contraception methods, and how to talk to teens about sex. The goal of this module is to provide accurate information, so KA parents can have well-informed conversations with their teens about their values around sex. The video begins with describing the research on sexual behavior among AA adolescents. After parents review a handout on STDs, the module continues with debunking myths about HIV/AIDS. Participants review the "Guide to Contraception" handout, so they can be informed of the various methods when having these conversations with their teens. The module concludes with the research on how parent-child communication influences teen sexual behavior and ways to effectively discuss sex with teens.

Module 9: Social Media Use

The Social Media Use module explains the effects of social media use, risk factors, and guidelines for mediating teen online activities. The video begins with information on the positive and negative impacts of social media use among adolescents. Citing the relevant research, the module continues with describing the risk factors that make some teens vulnerable to the negative outcomes associated with social media use. Understanding these risk factors allows parents to consider the appropriate mediation

strategies necessary for their teens. Guidelines for social media use are recommended with a handout for reference.

Module 10: Emotion Management

The Emotion Management module informs parents on effective skills to manage their emotions and a coping plan for times of high distress. First, the video describes the importance of emotion management when parenting adolescents to prevent impulsive actions and model emotion regulation for their teens. The module explains the link between emotions and body responses. Parents are instructed to complete the "Body Talk Symptoms" and "Feelings Thermometer" worksheets to help them identify their own physiological responses to strong emotions and the stage to intervene. Based on the previous exercises, the module guides parents through creating a "Stay Cool Plan," identifying early body responses and coping strategies during conflicts with their teen. Deep breathing and progressive muscle relaxation are taught as coping skills (handouts provided). For homework, parents are assigned to practice using their "Stay Cool Plan" and revise it as needed.

Module 11: Seeking Treatment

The Seeking Treatment module debunks myths about mental health, explains EBTs, and provides steps to finding a therapist and affordable services. The video begins with identifying common misconceptions about mental health in Korean culture based on values of willpower and "saving face." An explanation about EBTs is provided as well as resources to find the appropriate EBT for their teen's specific needs. The module outlines

the steps to finding the right therapist and options for affordable services (handout provided).

Current Study

The current study aimed to pilot the KFC Program to evaluate the therapeutic effectiveness among the target population of first-generation KA parents of second-generation adolescents aged 12-18. We hypothesized that the KFC Program would be associated with high participant acceptability and appropriateness based on its method of development. We also hypothesized that mental health literacy (i.e., anxiety, depression, and eating pathology), parent-child communication, and attitudes toward seeking professional psychological help would increase while mental health stigma and negative beliefs about mental illness would decrease from pre- to post-intervention. Lastly, we hypothesized that scores on the vignettes would improve after participating in the program.

Methods

Participants

Participants for the pilot study were recruited through national and local KA organizations, professional association listservs, Korean language schools, Korean churches, school counselors, local Korean newspapers, high school Korean American Parent Associations, Korean American Student Associations, and high school Korean clubs across the country. Study flyers were also shared on Korean social media groups. Researchers posted flyers at Korean retail stores across the country. Study emails were sent through contacts at AMITA Health and Children's National Medical Center. The

study was advertised as a parent training program to improve family harmony and positive youth development, teaching parents how to enhance the physical and emotional well-being of KA adolescents. Inclusion criteria for participants were as follows: first-generation KA parent with second-generation child between 12-18 years old and proficiency in English or Korean.

Of the thousands contacted, 20 individuals indicated interest through a Google Contact Form. Twenty-six participants consented to the study and completed the pre-intervention measures. The additional six participants may have resulted from participants directly sharing the Qualtrics link to the informed consent form and pre-intervention measures rather than first indicating interest through the Google Contact Form. From the initial 26 participants, 16 dropped out of the study. One participant stated that the 20-minute pre-intervention measures took too long. Three participants reported inability to complete the program due to time constraints and computer illiteracy. The 12 remaining participants were unable to be reached by researchers. One participant was removed due to not meeting the inclusion criteria.

Procedures

After indicating interest in the study, participants were emailed a Qualtrics link to the informed consent form. Once individuals agreed to participate, they completed a set of pre-intervention measures to provide baseline responses to mental health literacy, stigma, attitudes toward seeking services, parent-child communication, and vignettes. Participants were provided with a link to enroll in the KFC Program through the Canvas platform. On Canvas, they completed the program by watching the module video

presentations, filling out worksheets, and practicing skills for homework. As a self-paced program, participants were allowed to complete the modules in their preferred order and pace. However, researchers provided the following recommendations for completing the program: Day one (modules 1-3), Day two (modules 4-6), Day 3 (modules 7-9), and Day 4 (modules 10-11). After finishing the KFC Program, participants completed a set of post-intervention measures on Qualtrics. Researchers sent reminder emails for the program and post-intervention measures. Following the post-intervention measures, participants were mailed a gift of appreciation, an emotion management kit that included items (i.e., bubbles, chewing gum, stress ball, and lavender essential oil) that facilitate mindfulness when feeling distressed.

Measures

Demographics

At baseline, participants provided the following demographic information: age, gender, marital status, years lived in the U.S., age of children, and household income. The participants also indicated whether their child has ever received therapy.

The Depression Literacy Questionnaire (D-Lit)

The D-Lit (Griffiths et al., 2004) is a questionnaire that assesses mental health literacy specific to depression related to symptoms, management, treatment, duration, and differentiation between depression and other mental illnesses. The measure consists of 22 items with three response options: “true,” “false,” or “don't know.” Each correct answer receives one point. Higher scores indicate higher mental health literacy of depression.

The internal consistency (α = 0.70) and test-retest reliability (*r* = 0.71) were both acceptable (Gulliver et al., 2012).

The Anxiety Literacy Questionnaire (A-Lit)

The A-Lit (Gulliver et al., 2012) is a measure that assesses knowledge about anxiety, including symptoms, treatment, and risk factors. The questionnaire consists of 22 items with three response options: “true,” “false,” or “don't know.” Respondents score one point for each correct answer. Higher scores indicate higher mental health literacy of anxiety. The A-Lit demonstrated acceptable internal consistency (α = 0.76) and good test-retest reliability (*r* = 0.83) (Gulliver et al., 2012).

Parental Knowledge and Understanding of Eating Disorders Questionnaire

The Parental Knowledge and Understanding of Eating Disorders Questionnaire (Bryson et al., 2018) consists of 20 true-or-false statements about the signs, symptoms, popular myths, and complications of eating disorders. Scores are calculated by the percentage of correctly answered statements. This measure demonstrated acceptable internal consistency (α = 0.67) (Bryson et al., 2018).

The Parent-Child Communication Scale

Based on two existing scales, The National Longitudinal Study of Adolescent Health (Harris et al., 2005) and the Parent Adolescent Communication Scale (Barnes & Olson, 1985), the Parent-Child Communication Scale (Choi et al., 2012) is a 10-item questionnaire developed to use with Korean families to assess the openness in communication. Responses are made on a 4-point scale ranging from 1= Never or almost

never and 4 = Always. Higher scores indicate more open communication. The measure demonstrated good reliability (r = .81) (Choi et al., 2012).

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF)

The ATSPPHS-SF (Fischer & Farina, 1995) is a 10-item questionnaire that assesses attitudes regarding seeking help from mental health professionals. The measure is rated on a 4-point Likert-type scale ranging from 0 (disagree) to 3 (agree). Items 2, 4, 8, 9, and 10 are reverse scored. Scores are summed and higher scores indicate a more positive attitude toward seeking psychological services. The ATSPPHS-SF demonstrated good internal consistency ($\alpha = 0.84$) (Fischer & Farina, 1995) and acceptable test-retest reliability ($r = 0.78$) (Choi & Miller, 2014).

Beliefs Toward Mental Illness Scale (BMI)

The BMI (Hirai & Clum, 2000) assesses negative stereotypical views of mental illness. Respondents rate their level of agreement on a 6-point Likert-type scale ranging from 0 (completely disagree) to 5 (completely agree) on 21 statements describing stereotypical views towards mental illness. Higher scores reflect more negative beliefs about mental illness. In the primary validity study, the BMI demonstrated excellent internal consistency among American ($\alpha = 0.89$) and Asian students ($\alpha = 0.91$) (Hirai & Clum, 2000).

Vignettes

Five vignettes were developed by the first and senior authors describing various situations of an adolescent experiencing symptoms of depression, suicidal behavior, panic

attack, anxiety, and eating pathology. Participants read each vignette and answered a multiple-choice question about their response to the given situation. For example: Your daughter is experiencing poor concentration. She was an outgoing and straight A student until about 2 months ago. Her grades have slipped from As to Cs, and she has been feeling sad and irritable. She has started avoiding her friends and worrying about her grades. She states that she feels dumb, and that her classmates don't like her. She used to love playing basketball, but suddenly lost interest. She spends most of her time in her room alone. Response options include a) Don't give attention to the situation. She is a teenager, and this is just a phase that will pass with time, b) Get her a tutor to help with her grades in school, c) Tell her to cheer up and stop thinking negative things, and d) Share your concerns about her recent mood and behavior. Ask about how she is feeling and discuss seeking therapy. A score will be calculated based on percentage of correctly answered questions.

Acceptability of Intervention Measure (AIM)

The AIM (Weiner et al., 2017) is 4-item questionnaire on perceived intervention acceptability. For example, "The intervention meets my approval." The measure is rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). An average is calculated, and higher scores indicate greater feasibility. The AIM demonstrated good internal consistency ($\alpha = 0.89$) and test-retest reliability ($r = 0.83$) (Weiner et al., 2017).

Intervention Appropriateness Measure (IAM)

The IAM (Weiner et al., 2017) is 4-item measure of perceived intervention appropriateness. For example, “The intervention seems fitting.” The measure is rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). An average is calculated, and higher scores indicate greater feasibility. The AIM demonstrated good internal consistency ($\alpha = 0.87$) and test-retest reliability ($r = 0.87$) (Weiner et al., 2017).

Data Analysis

Data were analyzed using IBM SPSS Version 28.0.1.1. Baseline characteristics and outcome variables were summarized using descriptive statistics (frequencies, percentages, means, standard deviations). To examine the effect of the KFC Program on mental health literacy (i.e., depression, anxiety, and eating pathology), mental health stigma, attitudes towards seeking treatment, parent-child communication, and vignettes, we conducted a paired sample t-tests on pre- and post-intervention scores. Effect sizes of the KFC Program on hypothesized outcomes used Cohen’s d, categorized as “small, $d = 0.20$,” “medium, $d = 0.50$,” and “large, $d = 0.80$” (Cohen, 1988). Mean scores on the measures for acceptability and appropriateness were calculated to determine participate response to the program.

Results

Demographic Characteristics

The study sample consisted of 10 KA parents 46-65 years old ($M = 54.70$, $SD = 6.60$) who have lived in the United States for an average of 27.50 years. Of the sample, 90% were women, 100% were married, and 80% reported an annual household income of

$100,0001 or over. All participants had at least one child of adolescent age ranging from 13-17 years old (M = 14.55, SD = 0.83) and 60% indicated their child has received therapy. See Table 3 for participant demographics.

Participant Differences

As previously mentioned, 26 participants completed the pre-intervention measures; however, only 10 individuals completed the study. One participant was removed due to not meeting inclusion criteria, leaving 15 participants who completed only the pre-intervention measures. Researchers ran independent-samples T tests to compare participants who completed the program (Group 1), and participants who dropped out of the study (Group 2) on demographic and outcome variables at baseline. Group 2 were significantly younger (M = 48.94, SD = 4.47), had greater literacy on depression (M = 12.07, SD = 4.68), and had more positive attitudes towards seeking professional psychological help (M = 21.50, SD = 4.34) than Group 1. Mean differences on all other variables were insignificant. See Table 3 for details.

Table 3: Sample Demographics

Mean Comparisons between Group Demographics and Outcomes Variables at Baseline					
Variables	Group 1 *N* = 10 (%) Mean (*SD*)	Group 2 N = 15 Mean (*SD)*	χ^2	t	p
Age	54.70 (6.60)	48.94 (4.47)		2.83	0.01*
Gender identity			2.27		0.13
Man	1 (10)	3 (20)			
Woman	9 (90)	12 (80)			
Non-binary/third gender	0 (0)	0 (0)			
Prefer not to answer	0 (0)	0 (0)			
Marital Status			0.69		0.40
Single	0 (0)	0 (0)			
Married	10 (100)	14 (93.33)			
Bisexual	0 (0)	0 (0)			
Divorced	0 (0)	0 (0)			
Widowed	0 (0)	1 (6.67)			
Annual Household Income			2.92		0.40
Under $20,000	0 (0)	0 (0)			
$20,000-$40,000	0 (0)	0 (0)			
$40,000-$60,000	0 (0)	2 (13.33)			
$60,000-$80,000	0 (0)	1 (6.67)			
$80,000-$100,000	2 (20)	1 (6.67)			
$100,001 or over	8 (80)	11 (73.30)			
Years lived in the U.S.	27.50 (11.90)	21.27 (8.42)		1.54	0.07
Age of Children	14.55 (0.83)	14.64 (1.45)		-0.19	0.43
Child in Therapy (Lifetime)			2.78		0.09

Yes	6 (60)	4 (26.60)		
No	4 (40)	11 (73.30)		
Depression Literacy	8.10 (4.93)	12.07 (4.68)	-2.03	0.03*
Anxiety Literacy	8.30 (5.40)	9.60 (4.63)	-0.64	0.26
ED Literacy	15.90 (3.21)	16.00 (1.93)	-0.10	0.46
Parent-Child Communication	24.44 (3.40)	24.15 (2.23)	0.24	0.41
Attitudes Towards Seeking Services	14.67 (5.05)	21.50 (4.34)	-3.33	<0.01*
Beliefs about Mental Illness	54.78 (16.15)	47.27 (16.50)	1.22	0.12
Vignettes	55.55 (37.12)	69.09 (25.87)	-0.96	0.19

** $p < .05$*

Program Outcomes

On the measures of mental health literacy, the scores for depression, anxiety, and ED literacy significantly increased from pre-intervention (T1) to post-intervention (T2) with medium to large effect sizes (DLit: d = -0.66, 95% CI [-1.34, 0.04]; Alit: d = -0.61, 95% CI [-1.28, 0.08]; ED: d = 9.68, 95% CI [-7.19, -10.50]), suggesting improvements in this area. Unexpectedly, scores on the Parent-Child Communication Scale significantly decreased from T1 to T2 and a medium to large effect size (d = 0.65, 95% CI [-0.10, 1.36]), suggesting less open communication. Additionally, scores on the Beliefs Toward Mental Illness Scale (BMI) significantly increased with a large effect size (d = -0.97, 95% CI [-1.75, -0.15]), suggesting more negative attitudes toward mental illness. Scores on attitudes towards seeking professional psychological help and the vignettes trended towards improvement at T2 with a medium to large effect sizes (ATSPPHS-SF: d = -0.54, 95% CI [-1.22, 0.18]; Vignettes: d = -0.57, 95% CI [-1.26, 0.16]). Participants highly rated the KFC Program on acceptability (M = 4.55, SD = 0.55) and appropriateness (M = 4.53, SD = 0.69). See Table 4 for details.

Table 4: Outcome Variables

Means, Standard Deviations, and Effect Sizes for Outcomes at Pre-Intervention (T1) and Post-Intervention (T2).

Variable	Time 1 *M* (*SD*)	Time 2 *M* (*SD*)	T1 - T2 Effect Size Cohen's *d* (CI)	t	p
Depression Literacy	8.10 (4.93)	11.90 (2.92)	0.66 (-1.34, 0.04)	-2.10	0.03*
Anxiety Literacy	8.30 (5.40)	11.60 (2.46)	0.61 (-1.28, 0.08)	-1.94	0.04*
ED Literacy	15.90 (3.21)	85.5 (10.12)	9.68 (-7.19, -10.50)	-22.72	<.001*
Parent-Child Communication	24.44 (3.40)	22.22 (4.71)	0.65 (-0.10, 1.36)	1.95	0.04*
Attitude Towards Seeking Professional Psychological Help	14.67 (5.05)	17.44 (2.79)	-0.54 (-1.22, 0.18)	-1.61[a]	0.07
Beliefs Toward Mental Illness	54.78 (9.74)	74.67 (19.70)	-0.97 (-1.75, -0.15)	-2.92	0.01*
Vignettes	55.56 (37.12)	77.78 (6.67)	-0.57 (-1.26, 0.16)	-1.70[a]	0.06

* $p < 0.05$
[a]trend

Discussion

In the present study, a pilot trial was conducted to test the therapeutic efficacy, acceptability, and appropriateness of the KFC Program, a culturally adapted PT prevention program for first-generation parents of second-generation adolescents.

Focusing on providing culturally competent psychoeducation, the PT program targeted mental health literacy, mental health stigma, parent-child communication, and attitudes towards seeking mental health services to address the low-rates of service utilization demonstrated by KA adolescents. Overall, the KFC Program demonstrated promising preliminary effects. Participants exhibited significant increases depression, anxiety, and ED literacy after completing the program, indicating that the program was effective in providing psychoeducation on these topics. Unexpectedly, perceived openness in family communication decreased from T1 to T2. The decrease in openness in communication may be due to adolescent response to the new communication skills the KA parents implemented. During the stakeholder focus groups, parents mentioned concern about their teens reacting with confusion to the parents using these skills because of the unexpected unfamiliarity. Like Project SHAPE, developing an adjunct part of the program for teen participation may be helpful for the parents and adolescents to learn the new communication skills together to reciprocal buy-in. Additionally, parents may have perceived themselves as less open to communication after learning about effective communication in the program, skills unfamiliar to most KA parents due to cultural differences. The information may have provided insight into their communication challenges. Furthermore, perhaps the KA parents rated themselves as less open to communication after learning how much their communication style would need to shift to implement these skills with their teens. Another surprising finding was the increase in negative beliefs about mental illness. This result may be explained by the program's focus in providing psychoeducation in a manner that addressed the cultural discounting of

mental health problems, such as citing research on the negative consequences of untreated depression, anxiety, and EDs, so KA parents would recognize the seriousness of these issues, Additionally, results should be interpreted with caution due to the small sample size of the study. However, the results demonstrated a trend of improvement in attitudes towards seeking professional psychological services after participating in the KFC Program, so perhaps their increased mental health literacy and concern of the seriousness of mental disorders contributed to their willingness to seek treatment for their adolescents to prevent potential negative outcomes. Furthermore, another trend was found as the participants scored higher on the vignettes of how they would respond to various situations of an adolescent experiencing depression, suicidal behavior, panic attacks, anxiety, and eating pathology. This indicates that they learned how to respond to these situations appropriately and effectively from the KFC Program. According to ratings on the AIM and IAM, the participants agreed that the KFC Program was an acceptable and appropriate program, aligning with the stakeholder feedback from Study 1.

Limitations and Future Directions

Although the study had many strengths, including methodology of developing culturally sensitive material, positive participant reactions, and promising preliminary results on mental health literacy and help-seeking attitudes, a few limitations should be noted. Despite the researchers' extensive efforts, study recruitment was particularly challenging. Based on the literature, we expected difficulties recruiting participants in this known hard-to-reach population (Han et al., 2007). Researchers attempted to mitigate

this potential issue in the early stages of program development by creating connections with community stakeholders and requesting recruitment recommendations from focus group members. Previous research has found that Korean community gatekeepers (i.e., pastors, church leaders, ethnic organization leaders) play a critical role in connecting researchers to potential study participants (Han et al., 2007). While Korean community hubs were contacted to assist in recruitment, accessing and receiving buy-in from these gatekeepers as non-members of their specific organizations proved to be a significant barrier to recruitment, resulting in a small sample size.

To boost recruitment, researchers offered a gift as incentive for study participation. However, this strategy was found ineffective as participant interest did not increase after advertising the incentive and most participants declined interest in the gift after study completion. A few previous studies on parenting programs for KA parents provided monetary incentives (Kim et al., 2008, 2014) with slightly higher sample sizes (29 and 48). In future studies may benefit from offering monetary incentives to boost recruitment with this population.

Another limitation was the high attrition rate. Of the 25 eligible participants who consented and filled out the pre-intervention measures, 10 completed the study. When comparing means between groups on demographics and outcomes variables at baseline, those who dropped out were younger, knew more about depression, and had more positive attitudes toward seeking services. These participants may have left the program believing they did not need it. Moreover, when researchers contacted the participants, most reported time constraints and difficulties with computer literacy while others were

unable to be reached. The time constraint issue aligns with previous research findings that age-related lifestyle priorities impact recruitment of middle-aged KA parents due to balancing busy schedules with home and work, and placing program participation low on their list of priorities (Choi et al., 2016; Han et al., 2007). One study found that a main retention barrier was due to a lack of motivation that while the parents understood the importance of their children's mental health, they did not feel a sense of urgency or obligation to remain in the study (Choi et al., 2016). Additionally, participants had difficulty with navigating the Qualtrics measures, forgetting their study ID numbers, incorrectly responding to the eligibility screener questions, and leaving the pre-intervention measures incomplete. Participants also reported difficulty understanding how to enroll in the KFC Program through the Canvas Platform. While the program was developed as a web-based program to address the cultural value of "saving face," the online platform created additional issues making program completion more difficult for some participants.

Future studies could include an adjunct teen program, so parents and their adolescents can learn together and be aware of the skills being practiced improving receptiveness. Future studies may also consider running the KFC Program in-person and providing monetary incentive. Additionally addressing recruitment barriers will be vital in testing this program in a larger sample.

APPENDIX

Focus Group Guide

Hi everyone! Welcome to the first focus group for the Korean Family Communications Program. My name is Naomi Pak and I'm a clinical psychology PhD student at George Mason University. Thank you so much for taking the time to participate in this study and attending the focus group today. Before we get started, I want to remind everyone that this session will be videorecorded, and I will be taking notes as well. I will begin the video recording after introductions in order to maintain confidentiality. Let's begin with introductions so we can know everyone's names before going over some group rules. We can go around and say our name. I can start. As mentioned at the beginning, my name is Naomi Pak and I'll be facilitating this focus group today. [Introductions] I'm now going to start the video recording.

Let's go over some group rules. First, participation is entirely voluntary. You may leave this session at any time without penalty. Second, everything we discuss today will be confidential and no identifying information will be collected. Third, in order to maintain confidentiality, it is important that all participants do not discuss the content of the session to anyone outside the focus group. Fourth, as difficult topics may come up, I ask that everyone respect each other, so that all participants feel comfortable sharing. If you agree to these group rules, please say yes. If you experience distress during the session, please message me using the "Chat" function on WebEx to let me know that you are stepping away to take a break and whether you need additional support. You can email me at KFCProgram@gmail.com and I'll be happy to schedule a separate meeting with you.

During today's focus group, we will discuss general feedback and reactions to the manual, the program structure, recommendations for recruitment, suggestions for manual improvement, and views on cultural aspects of the manual. Let's get started!

1. What are your thoughts and impressions about the information presented in the KFC Program?
2. What suggestions do you have for this program?
3. Would you be interested in this program?
4. What did you like about it?
5. What did you dislike about it?
6. Did you learn anything new? If so, what did you learn that was new to you?

7. Could you relate to examples about Korean culture? If so, which examples could you relate to?
8. Is there anything you disagreed with related to the Korean culture examples that were presented?
9. Is there anything that you would want to add about Korean culture to these topics? If so, what would you add?
10. Would you prefer your child see a therapist that is Korean or not? Does that matter?
11. Is there anything missing that you would like to see in the program? If so, what?
12. Did you find this helpful and how?
13. In what ways, if any, did it change your views?
14. Should we add in a substance use and risky sexual behavior module? If yes, what would you like to learn about these topics? If no, why not?
15. Do you think Korean parents would be receptive to learning about substance use and risky sexual behavior?
16. What did you think about the length?
17. What is your preferred format of the web program (i.e., slides, someone presenting info, combo, a course)?
18. How many sessions would you like this material presented in?
19. How many sessions would you be willing to complete if you were a parent in this program?
20. How long should the sessions be?
21. What are your thoughts on the intervention measures?
22. What suggestions do you have for recruiting parents for this program?

As a reminder, you can respond to these questions anonymously online if you feel more comfortable providing feedback this way or if you have any additional comments to share following the session. Feel free to email me if you have any additional ideas you would like to share with me. Would you be okay with me following up via email or phone if I have any additional questions after today's focus group?

Your feedback will be reviewed and used to modify the manual. I will email each of you the revised manual for a final review along with a link to the same 3 questionnaires to complete based on the new manual. You'll fill out another poll with your availability to determine the day and time for the final focus group. Once we end today, I will email each of you a $75 Visa e-gift card. Thank you so much for participating in the focus group today and providing such helpful feedback!

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