WHAT ARE THE EXPERIENCES OF SOUTH KOREAN IMMIGRANT PARENTS WHO HAVE A CHILD WITH AUTISM SPECTRUM DISORDER

A Dissertation submitted to the Kent State University College of Education, Health and Human Services in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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The purpose of this study was to examine the experiences of South Korean immigrant parents who have a child with autism spectrum disorder (ASD). The participants in this study were interviewed utilizing the phenomenological qualitative research method. The participants were asked to answer semi-structure open-ended questions throughout two to three interviews.

The participants in this study were six South Korean immigrant parents, ages 36-48, of children who have been diagnosed with ASD. The results of this study suggest five major themes supported by the data provided by each participant. The themes were: a) Familial support during adjustment, b) Religion and spirituality, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness, and e) Cultural differences during adjustment. More details were covered under each sub-theme of the major themes.

Further research should be completed in order to study more South Korean immigrant parents from different parts of the country. The research can also extend to other Asian and minority populations, such as Chinese and Japanese immigrants, who share the same views of shame, guilt, and embarrassment toward individuals with special needs.
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CHAPTER I
INTRODUCTION AND LITERATURE REVIEW

Immigration is a stressful process. Leaving your country of origin, legalities, and immigrating can all be stressors. According to Brannon (2003), many stressors are inherent in the acculturation process, including learning a new language, discovering new cultural traditions, and coexisting with both the native and host cultures. Having a child with a developmental disability may amplify the acculturative stress in a family. Immigrants to the United States often do not come from a culture or socioeconomic background where diagnosing and treating developmental disability is common. Even if the immigrants were willing to seek treatment for a child, navigating institutions and resources could be challenging for families struggling with acculturation.

In the Korean culture, mental health is an issue that has been commonly disregarded, stigmatized, or misdiagnosed. Many individuals in the Korean community misunderstand what mental health issues entail, and find it difficult to receive the correct mental health services needed. Issues and stressors related to immigration can be properly addressed if mental health services were sought.

One particular mental health issue that garnered a great deal of attention in the 2000s was autism spectrum disorder (ASD). For unclear reasons, diagnoses of ASD rose significantly in that decade and the Korean community was no exception. According to Bower (2011) and the Center for Disease Control (2014), ASD affects 2.64% of South Koreans as compared to 0.07% and 1.8% found in United States, England, and other parts of the world. About 33% of children diagnosed with ASD in South Korea attended
public schools where their condition had gone unrecognized. This may have been due to strict cultural beliefs regarding what “normal” child behavior was (Bower, 2011).

According to the *Diagnostic and Statistical Manual [DSM-V]* (American Psychiatric Association, 2013), those diagnosed with autistic disorder exhibited persistent deficits in social communication and social interaction across multiple contexts, as well as restricted, repetitive patterns of behavior, interests, or activities. These symptoms caused clinically significant impairment in social, occupational, or other important areas of current functioning usually acquired within the first three years of life. Due to the prevalence of autism spectrum disorder, understanding this disorder and its facets is important for health care professionals. According to the Center for Disease Control (2014), autism spectrum disorders (ASD) are the most common serious developmental disability after mental retardation and intellectual impairment, but are still less common than other conditions such as speech and language impairments, attention deficit–hyperactivity disorder (ADHD), and learning disabilities.

In the past decade, the diagnosis of autism spectrum disorder (ASD) - a spectrum of diagnoses that encompasses social communication disorder and autism spectrum disorder - increased dramatically. In the year 2000, the prevalence of children with ASD was estimated to be 1 in 150 but by the year 2014, the estimate was revised to 1 in 68 (Center for Disease Control, 2014). The reasons for this increase are unclear, though it is speculated that it was due to changes in ASD classification, rather than an increase in frequency (Matson, Kozlowski, Hattier, Horovitz, & Sipes, 2012).
Having a family member with ASD creates tension and other stresses within the home environment (Midence & O’Neill, 1999). Potential problems may arise due to the individual with ASD needing extra attention that may be taken from other members of the family. This imbalance of attention can result in sibling rivalry, marital discord, and other extraneous issues. Immigrant families who have undergone acculturation experience a similar process when adjusting to the diagnosis of their child with ASD (Min, 1998).

The current study investigated the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. It focused on the experiences of South Korean immigrant parents who have a child with autism spectrum disorder and concentrate on how these parents adapt to a new host culture while caring for a special needs child. The research centered on the South Korean immigrant population, rather than both South and North Korean cultures, due to the availability of information on South Korean immigrants and the large cultural differences between South and North Korea (Hurh & Kim, 1990).

**Purpose of the Study**

The purpose of this study is to examine the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. The data from this study will begin to address the gap in the current scholarly literature and build upon the minimal amount of known scholarly literature regarding the South Korean immigrant population as it relates to the autistic population. The specific focus on the autistic population is critical due to the rise in its prevalence. This study is also important in
addressing the increasing numbers of both South Korean immigrants and children diagnosed with ASD. Due to the acculturation experience that the South Korean immigrants face, raising a child with ASD proves to be an added challenge. The information gathered from this research may begin to explore how these experiences can be applied to improving treatment of mental disorders in children within the greater South Korean immigrant community.

The results of this research may also help families learn more effective coping skills in order to attend to and satisfy the individual needs of all family members. For counselors and other mental health professionals, it may be beneficial to understand how caring for a child with ASD may strain family relationships and to learn the most effective coping skills to reduce that strain.

Conducting the present qualitative research may help teachers better understand their students with ASD and their siblings who may show adjustment problems. This study may also help to identify different clinical issues surrounding South Korean immigrant parents and the adjustment to raising a child with autism spectrum disorder.

**Research Question**

Although certain research exists regarding South Koreans’ views on mental health (Chu & Sue, 2011; Das & Kemp, 1997; Fan, 1999) and parental adjustment to ASD (Dunlap, Plienis, & Robbins, 1998; Midence & O’Neill, 1999; Pargament & Raiya, 2007), there are currently no published studies completed in the area of South Korean immigrant parents’ experiences of having a child with autism spectrum disorder. By asking the question of what the experiences are of South Korean immigrant parents who
have a child with autism spectrum disorder, the findings will add to the existing research and provide this topic with more pertinent information. The research question is, “What are the experiences of South Korean immigrant parents who have a child with Autism Spectrum Disorder?”

**Definition of Terms**

For the purpose of this study, the following definitions of terms will be utilized:

- *Acculturation* is defined as the process of becoming accustomed to a new culture (Berry, 1990). Acculturation is also an important issue related to the cultural and psychological changes that occur when individuals from different cultural groups come into contact (Berry, 2006).

- *Assimilation* is defined as absorbing portions of the new culture into the existing immigrant culture (Berry, 1980). It is often defined as a negative experience within the immigrant culture but a positive experience within the host culture. Assimilation is also defined as the coming together of two distinct cultures to create a new and unique third culture (Diller, 2007).

- A *child with autism spectrum disorder* is defined as an individual diagnosed anywhere along the autistic spectrum by a licensed professional, including Social Communication Disorder & Autism Spectrum Disorder (APA, 2014; Autism Speaks, 2014; Matson et al., 2012).

- A *family unit* consists of a father, a mother, a child diagnosed with autism spectrum disorder, and any siblings.
Integration denotes a positive experience within both immigrant and host cultures during the acculturation process (Berry, 1980).

Marginalization is defined as relegating to an unimportant or powerless position within a society or group and is viewed as a negative experience in both immigrant and host cultures (Berry, 1980).

**Literature Review**

The literature review covers four areas. The first area is the literature on autism spectrum disorder which details the increase in prevalence and diagnoses over the past decade and how it has affected those diagnosed. The second area is on immigration and the acculturation of immigrant communities and the difficulties and stresses they face when adjusting to their host culture. The third area of research is on South Koreans which outlines their beliefs on mental health, cultural differences from the United States, and the difficulty individuals from this culture have in acculturating and assimilating into the Western culture. The fourth and final area is an exploration of the literature on the perceptions of children with disabilities and impairments; the perceptions of educators, parents, and South Koreans as well as parents’ experiences with children who have autism spectrum disorder.

**Autism Spectrum Disorder**

Autism spectrum disorder has been a topic of interest for many researchers due to its different facets since its introduction. Some characteristics of ASD include impairment in reciprocal social interactions, impairments in verbal and non-verbal communication skills, and repetitive behaviors and interests (APA, 2014; Matson, Hess,
Impairment in social interactions may be manifested through lack of social or emotional reciprocity, lack of spontaneous sharing of experiences with others, and lack of nonverbal behaviors such as eye contact, facial expressions, and body postures (Volkmar, Siegel, Woodbury-Smith, King, McCracken, & State, 2014). Impairment in communication skills may be manifested through delays in or lack of language development or in peculiar patterns of speech such as in excessively high volume or a pitchy tone (Hattier & Matson, 2012). Impairments may change in those diagnosed with ASD over time. For instance, infants initially want to be cuddled but change over time of their development to a notable indifference or an aversion to affection and physical contact. The classic case of ASD can be characterized by lack of eye contact, facial responsiveness, or socially directed smiles, as well as by failure to respond to parents’ voices (APA, 2014; Holzer, Mihai, Rodrigues-Degauff, Junier, Muller-Nix, Halfon, & Ansermet, 2006).

Dewey and Kaminski (2002) reported that having a child with autism spectrum disorder in the family placed non-disabled siblings at an increased risk of externalizing adjustment problems, as in aggression and external behaviors, and internalizing adjustment problems, as in depression. Siblings of a child with ASD need a stronger support network compared to those of typically developing children and their siblings (Doppelt, Gross-Tsur, Pilowsky, Shalev, & Yirmiya, 2004). If families, teachers, and other professionals have not discovered an effective way to deal with siblings of a child with ASD, then how will they cope when the child becomes older? Siblings of a child
with ASD may also experience poor psychosocial adjustments and display symptoms of depression and lack of interest in peers and other aspects of their daily lives.

**Diagnosis and prevalence.** Autism Spectrum Disorder (ASD) is a developmental disability that causes substantial impairments in social interactions and expressive and/or receptive communication styles (Matson et al., 2012). Those diagnosed with ASD may also have unusual behaviors or interests. Some of these behaviors include repeated body movements called “self-stimulation” in the form of hand flapping, rocking, and other actions (APA, 2014; Matson et al., 2010). Some individuals diagnosed with ASD engage in extremely aggressive and self-injurious behaviors (Mash & Wolfe, 1999). Many have unusual ways of learning, paying attention, and reacting to different sensations. The cognitive abilities of individuals diagnosed with ASD can vary from gifted to severely challenged. Autism spectrum disorder impacts a typically developing brain in the areas of social interactions and both verbal and non-verbal communications. Autism spectrum disorder occurs in all racial, ethnic, and socioeconomic groups and is four times more likely to occur in boys than girls (CDC, 2014).

There have been different theories in hopes to explain the rapid increase in prevalence of autism spectrum disorder (Fombonne, 2009; Kim, 2011; Kim, 2014). According to Bower (2012), the increased prevalence of ASD is not accurate due to the information relying on school and medical records rather than assessments done in person. The prevalence also does not take into consideration the minority populations and those living in the lower socioeconomic groups who may not have access to or
knowledge of ASD in order to get their child properly tested (Bower, 2012). There also may be a discrepancy with children who truly have ASD versus those children who get diagnosed with ASD in order to take advantage of the special education services (Matson et al., 2012).

The rapid increase in prevalence could also be explained by the highly educated and wealthy populations seeking more testing and services for their child (Grinker, 2007). As this phenomena leveled out, its effects were passed down to those living in lower socioeconomic areas providing them with the knowledge of services. As a result, children in these areas were more likely to be diagnosed as compared to years prior (King & Bearman, 2011).

Although there have been changes in diagnostic criteria coupled with an increased awareness of autism spectrum disorder (Grinker, 2007; Matson et al., 2012), these two factors alone could have contributed to the increased reported prevalence. King and Bearman (2009) conducted an extensive study of California’s birth and medical records and found that ASD diagnoses before the age of five have increased from 6.2 per 10,000 in 1990 to 42.5 in 10,000 in 2001.

Researchers debate whether the social impairments in autism spectrum disorder result from a social or cognitive deficit because of the complex cognitive processing required to communicate with others (Ruble, 2001). Social behaviors have been linked to certain abilities such as rapid shifting of attention, processing of complex stimuli, and maintenance of goal-directed behaviors (Smith & Matson, 2010). Social interactions require these abilities and the abilities to attend to a multitude of cues (Grecucci et al.,
These cues then require interpretation and appropriate responses in order to continue the social interaction. Individuals diagnosed with ASD are unable to interpret these social cues or connect a social cue to the appropriate response, resulting in disengagement or an overstimulated reaction (Avikainen, Wohlschlager, Liuhanen, Hanninen, & Hari, 2003; Rogers, Hepburn, Stackhouse, & Wehner, 2003). For example, if a mother is making direct eye contact and making “baby talk” with her child, the child developing typically would smile back and coo at the mother. A child diagnosed with ASD may look away or begin to cry as s/he does not know how to properly respond to the social initiation from the mother. Not only does this cause distress for the mother who is making an effort to engage her child, it also creates distress for the child and may cause overstimulation (Ruble, 2001).

**Causes.** There is not one clear definition or source known to cause autism spectrum disorder, but there has been a significant amount of research done on the different theories of the exact causes of ASD. One of the theories has to do with the age of the parents when the child is born. With parental age increasing for children born between 1992 and 2000, the age of the parents is strongly associated with an increased risk of having a child diagnosed with ASD (Liu & Bearman, 2010). According to King et al. (2009), maternal age was found riskier than the paternal age as the cause of ASD.

A genetic component is also being offered as a theory for the cause of ASD. Geschwind (2011) stated that ASD involves a wide range of genes as opposed to one hereditary factor. The genetic factor involves a rare mutation, gene interaction, and other factors such as gene x (Stankiewicz & Lupski, 2010). The mutations were more
frequently derived from fathers with increased age (O’Roak et al., 2012). Although genetics may account for a small percentage of the cause of ASD, Hallmayer et al., (2011) believed that environmental factors were more to blame than genetics alone.

Although there is little research to support these claims surrounding environmental risk factors, Schmidt (2011) believed that mothers living next to freeways during their third trimester may have an increased risk compared to mothers who take prenatal vitamins around the time of conception who have a decreased risk. Another environmental toxin considered was chemicals, such as pesticides and mercury. In a study conducted by Geier and Geier (2009), it was found that in 100 women who had amalgam dental fillings, those infants whose mother had six or more fillings were more likely to be diagnosed with ASD as compared to those mothers with less than five fillings. According to the U.S. Food and Drug Administration (2014), amalgam is a mixture consisting of liquid mercury and powdered alloy made from silver, tin, and copper with 50% being mercury.

The final theory regarding the cause of ASD is the mercury in childhood vaccinations (DeStefano, 2007). With any medical intervention, vaccinations come with risks. But the benefits of receiving vaccinations far outweigh these risks (Poland & Jacobson, 2000). An article published in 1998 regarding vaccinations and ASD caused the public to misinterpret its meaning and it is believed the sensationalizing of the article by the media resulted in parents not vaccinating their children or discontinuing vaccination schedules which were already started (Poland & Spier, 2010). The panic was
compounded by a delayed and unclear response by the public health authorities, which resulted in an avoidable tragedy of many children becoming sick and dying (Stein, 2011).

Treatment. Various treatment options and their impact on ASD have been extensively researched (Howlin, 2009; Reichow & Wolery, 2009; Virtue-Ortega, 2010). Treatment options have become more available for individuals diagnosed with autism spectrum disorder. There are many treatment options that may be explored in order to find a proper fit for each specific child. With appropriate services, support, training, and information, children diagnosed with ASD may grow, learn, and flourish even though it may be at a different developmental rate than typically developing children.

Although there is no known cure for ASD, there are treatment and education approaches that may reduce some of the challenges associated with the diagnosis (Cohen, 1998). Treating ASD is complicated because no two individuals diagnosed with ASD are alike (Seiler, 2011). This denotes that no single treatment will be effective for all individuals diagnosed on the spectrum. Those individuals diagnosed can learn to function within their diagnosis and utilize the positive aspects of their treatment to their benefit. Behavioral interventions may help to lessen disruptive behaviors such as self-stimulation and injurious behaviors, and education can teach self-help skills that allow for greater independence such as getting dressed and going to the bathroom.

Beginning treatment as early as possible has proven to be beneficial (Cohen, 1998). Although early intervention is emphasized, rushing into a treatment option that may be inappropriate for the child may be potentially harmful. Information concerning various treatment options should be gathered and investigated before proceeding. When
a method of treatment is chosen, it must be tailored to the child’s unique strengths, weaknesses, and needs. Multiple treatment modalities may need to be utilized in order to find one that resonates with the individual. It is important to match a child’s potential and specific needs with the treatment or similar effective strategies when choosing a treatment option. The basis for choosing a treatment option should come from a thorough evaluation of the child’s strengths and weaknesses. Understanding the learning differences of every child is an important first step in assessing whether a certain treatment modality will be successful or not. The treatment options covered are typically utilized for children under the age of three, but they may also be included in an educational program for older children.

When choosing treatment options for a child who is three years and younger, a federally funded program called “early intervention” is available in every state through various agencies (Paynter & Keen, 2014). This early education assistance may be available for home-based use or school-based use. Members of an early intervention team are generally assigned to make home visits to train the caregivers to properly educate the child diagnosed on the spectrum for home-based programs. School-based programs may take place in a public school or a private organization. In utilizing any early education assistance, both in and out of the home, the programs should be staffed by trained professionals and teachers who have specific training and experience with children diagnosed with autism spectrum disorder (Stahmer, Collings, & Palinkas, 2005). Services such as physical and occupational therapy, speech therapy, and other services depending on the child’s needs should be offered in conjunction with the early education
assistance program. The program may be solely for the child with a developmental disability or it may also include typically developing peers (Stahmer, 2007).

**Learning approaches to autism spectrum disorder.** Many of the treatment options that will be outlined in this section have been developed to address the range of social, language, sensory, and behavioral difficulties that may be associated with autism spectrum disorder. The exhibition of certain behaviors among children with ASD may be the most troubling aspect of the developmental disability for parents, professionals, and caregivers (Waters, 1990). These behaviors may be aggressive, repetitive, sometimes dangerous, and mostly socially inappropriate. They may include rocking, head banging, hand flapping, and finger snapping. Children diagnosed with ASD may also engage in behaviors that are considered to be self-injurious, such as biting themselves or eye gouging. These individuals may show little to no sensitivity to bruises, cuts, burns, or other injuries and may also become physically aggressive without being provoked.

Both spoken and written communication may present a challenge for children on the autism spectrum (Bennett et al., 2014). The lack of language and speech development may also lead to behavioral problems. Some children have difficulty understanding the functions of reciprocal communication. Many of these children may also utilize language in a unique way, such as by choosing to use only one or few words or repeating a certain word or phrase, called echolalia (Sterponi & Shankey, 2014). The following sections will outline some treatment approaches which are commonly used in order to address problematic and unwanted behaviors in children who have ASD.
**Applied behavior analysis.** Applied Behavior Analysis (ABA) is used to treat children on the autism spectrum. Discrete trial techniques are utilized in ABA, which focuses on behavior modification by changing the environment’s stimulants and consequences through the use of positive reinforcement (Karst & Vaughan Van Hecke, 2012). ABA states that behavior rewarded is more likely to be repeated rather than behavior ignored. ABA is the balance of applying principles, which are experimentally derived, in order to improve socially significant behaviors. ABA utilizes the existing behaviors within the client and applies them toward bringing out positive changes. The behaviors are measured and observed over time and then analyzed within the client’s environment to determine the influencing factors of the behavior (Lovaas, 1987).

ABA is an intensive and time consuming approach. On average, children engaged in ABA work from 30 to 40 hours a week with a trained professional. Some professionals feel that being engaged in therapy 30 to 40 hours a week is too intensive for children with ASD and too intrusive on the families involved. Some may also feel that it may be too emotionally difficult for the ASD population and while it may change a particular behavior, it may not necessarily prepare a child to respond to new situations. However, research has revealed that ABA techniques show consistent results in teaching new skills and behaviors to children on the autistic spectrum (Lovaas, Koegel, Simmons, & Long, 1973; McEachin, 1993).

Discrete trial training is a subset of ABA and is utilized within its treatment. In discrete trial training, the goal tasks are broken down into short simple pieces or trials (Landa, 2007). Every command given to the child consists of a request to complete or
perform a specific action, a response from the child, and a counter response from the therapist. The main goal is not to correct the behavior but to teach basic skills such as sleeping and dressing, and more advanced skills such as social interactions and play. When the requested task is successfully completed, a reward is offered, which reinforces the desired behavior or task (Smith, 2001).

In undergoing Applied Behavior Analysis (ABA), some children with ASD reach a plateau. This plateau is described by the Center for Autism and other Related Disorders (CARD) headquarters as a level of “normal functioning.” This means that the child is able to attend school without a shadow aide, receive normal scores on different tests, and cannot be differentiated from normally developing children. Reasons to terminate ABA other than reaching a plateau may include lack of funding, scheduling issues, relocation, and lack of parental involvement (Center for Autism and other Related Disorders, 2007).

**Relationship development intervention.** Relationship Development Intervention (RDI) is a program which educates and coaches professionals and parents of children with ASD. This program is led by the therapist and parents but is supportive of the interaction between the parent and the child (Gutstein, Burgess, & Montfort, 2007). The RDI program provides an avenue for parents to teach friendships, empathy, and the love of sharing their experiences with others to their children with ASD (Gutstein, Burgess, & Montfort, 2007). A focus for the RDI consultants is to educate and train parents to systematically teach their children with ASD the skills of interacting with others by sharing their experiences. The individuals with ASD may learn to tolerate and accept changes and transitions through the use of this program. The consultants working with
RDI are specially certified and aid parents in implementing and customizing a RDI program that is specifically tailored for their child with ASD. These consultants utilize an assessment given through the RDI program called the Relationship Development Assessment (RDA) to develop specific, clear, and developmentally appropriate objectives and customized activities for the parents to use with their children. RDI claims that if executed correctly, the child with ASD could improve in meaningful communication, skills to share with others, curiosity and enthusiasm for others, ability to adapt to changes, spontaneous initiation of joint attention, and peer interactions (Gutstein & Sheely, 2002).

**Picture exchange communication system.** The Delaware Autistic Program developed Picture Exchange Communication System (PECS) in order to aid children and adults with ASD in acquiring practical and efficient communication skills. It uses the ABA theory of rewarding the correct behavior to teach these children to exchange a picture of the desired item or activity to communicate their needs. For example, if the child needed to use the bathroom, s/he would retrieve a picture of the bathroom and take it to the caretaker in order to communicate their needs. Some children diagnosed with ASD may learn to communicate while others may never develop verbal language (Bondy & Frost, 2011).

A communication system such as Picture Exchange Communication System (PECS) is helpful for these children to start building their language and communication skills as well as to provide a way of communication for nonverbal children (Tincani, Crozier, & Alazett, 2006). The clear advantage of utilizing PECS is that it is child-initiated and intentional (Carr & Felce, 2007). If an icon of an item or activity is
shown, the child’s request is immediately understood, which creates a more gratifying experience for the child (Bondy & Frost, 2011).

**Social stories.** Carol Gray created social stories in 1991 as a tool to teach social skills to children diagnosed with ASD. These stories are designed to aid the individual in recognizing feelings, points of view, and plans of others (Kokina & Kearn, 2010). Stories are written for specific situations pertaining to the child and are provided with as much information as possible to help him or her to understand the expected and appropriate response to the situation (Crozier & Tincani, 2007). These stories are typically created with three different sentence types: descriptive, perspective, and directive sentences. The descriptive sentences address the elements of who, what, when, where, and why in the situation (Laprime & Dittrich, 2014). The perspective sentences provide understanding of the thoughts and emotions of others. Directive sentences suggest an appropriate response. These individual and situation-specific stories can be written by anyone. The stories frequently incorporate pictures, photographs, or music and are written in the first person and present tense.

Before social stories are utilized, it is important to determine how the child interacts socially, which situations are difficult or produce stress, and under what circumstances these difficulties occur (Revnhout & Carter, 2006). Topics that are appropriate for the use of social stories may include tantrums, crying, or situations that may produce anxiety, fear, stress, or which make a child want to withdraw. The stories must be centered not on the specific behavior itself, but on how the child can deal with the feelings that arise from such behaviors or events (Kokina & Kearn, 2010).
**Treatment and education of autistic and related communication of handicapped children.** The treatment and education of autistic and related communication of handicapped children (TEACCH) method was the first statewide program for treatment and services for people with autism spectrum disorder. The method was developed at the University of North Carolina in the 1970’s (Blubaugh & Kohlmann, 2006). TEACCH believes and is based on the idea that the environment should be adapted to the child with ASD and not the other way around. It also emphasizes individual strengths of the child with ASD and focuses on a high level of participation and collaboration from the parents (Schopler, Mesibov, & Baker, 1982). There is no one specific technique, but rather a program developed around the child’s level of functioning. The individual’s abilities to learn are thoroughly assessed using the Psycho Educational Profile (PEP), and strategies are developed and designed to improve communication as well as social and coping skills. The focus of the TEACCH approach is to provide the child with the skills to understand his or her world and other people’s behaviors, rather than teach the child a predetermined set of skills (Mesibov & Shea, 2010).

The TEACCH method of treatment may be viewed as being too structured. Children with ASD may become too focused on the charts, schedules, and other organizational aids. It’s been stated that these distractions may discourage the child from mainstream behaviors, which means that the child may only respond to specific stimuli used within the program and not within everyday situations. Others feel that if the learning environment is conducive to the child, then the child with ASD will understand
what is to be expected and how to appropriately respond (Mesibov, Shea, & Schopler, 2005).

**Pivotal response treatment.** Pivotal response treatment (PRT) is a naturalistic approach to working with individuals who have autism spectrum disorder. It focuses not on each individual behavior at a time but on producing positive changes in critical behaviors which lead to the generalized improvement in communication, social, and behavioral areas (Koegel & Koegel, 2006). The motivational strategies which underline the PRT approach are incorporated as often as possible throughout treatment. These strategies include child choice, interspersing maintenance tasks, task variation, rewarding attempts, and using direct and natural reinforcers (Bryson, Koegel, Koegel, Openden, Smith, & Nefdt, 2007). An example of a direct or natural reinforcer may be a child receiving a certain toy or food that was requested rather than using a piece of candy or other related reinforcer. The PRT approach has been utilized to teach language, increase social skills, decrease disruptive or dangerous behaviors, and increase communication and academic skills (Koegel, Bradshaw, Ashbaugh, & Koegel, 2014).

**Floor time.** Floor time is an educational model which provides a comprehensive framework that aids professionals in understanding individuals with autism spectrum disorder and related disorders. The main goal of floor time is to master the individual’s ability to relate to others, communicate, and think, rather than to focus solely on the symptoms (Brazelton & Greenspan, 2007). Floor time, like play therapy, provides the individual with ASD a chance to interact with an adult in a developmentally based sequence and develop relational skills. Greenspan describes six stages of emotional
development that children must meet in order to develop a foundation for more advanced learning to occur. Individuals diagnosed with ASD and related disorders may have great difficulties in working through these developmental stages due to such obstacles as having difficulty processing information, difficulty controlling their bodies, and over and under reacting to senses (Greenspan, 2006).

**Sensory integration.** Individuals diagnosed with autism spectrum disorder may have sensory difficulties, such as hypo or hyper reactive senses. Sensory integration therapy focuses on desensitizing and helping the individual to reorganize sensory information (Iarocci & McDonald, 2006). If a child is having trouble with the sense of touch, sensory therapy may include exploring different textures and pressures as well as handling different objects. Auditory integration therapy may be used with individuals who have a hypersensitivity to sound. This therapy may involve having the child listen to a variety of different sounds and frequencies coordinated to the level of the individual’s impairment. These therapies are usually done with occupational, physical, or speech therapists. Before choosing to engage in this method of treatment, however, it is important to observe the individual and have a clear understanding of the specific sensory sensitivities and deficits (Kranowitz, 1998).

**Complementary approaches.** Complementary approaches are defined as different types of therapies that have been developed to be used individually or incorporated into an educational program. These approaches have little scientific research to validate their effectiveness but are considered to be beneficial (Levy & Hyman, 2002). Complementary therapies may include music, art, or animal therapy. These approaches
to treatment can be a non-threatening way for the child to develop a sense of accomplishment, as well as provide a safe place to potentially increase communication and social skills with the working therapist.

Art and music are particularly useful in sensory integration because they provide tactile, auditory, and visual stimulation. Learning lyrics to songs can be used to increase speech development and language comprehension (Kern, Rivera, Chandler, & Humpal, 2013). Art therapy can provide a unique way to express feelings or communicate nonverbally or symbolically (Martin, 2009). A popular form of animal therapy is horseback riding. Therapeutic riding programs may provide both physical and emotional benefits, such as improvements in coordination and balance (Wuang, Wang, Huang, & Su, 2010).

**Facilitated communication.** Facilitated Communication (FC) was developed in the 1970’s. The treatment method is based on the foundation that an individual may be unable to communicate because of a movement disorder rather than a lack of communication skills (Kezuka, 1997). In facilitated communication, a facilitator may physically support an individual’s hand or arm in order to help the individual communicate through the use of a computer or typewriter. This approach to working with autistic individuals has not been scientifically validated and has received criticism that the communication may be influenced by the facilitator.

**Parent training.** One of the most prevalent and cost-efficient means of intervention for children with autism spectrum disorder is parent training (PT). Parent training broadly refers to programs or trainings designed to teach them skills to use with
their children or to provide information (Schultz, Schmidt, & Stichter, 2011). In parent training, the parent is presented with a variety of strategies and skills by the therapist but the therapist has little to no direct contact with the child in day to day treatment (Karst & Vaughan Van Hecke, 2012).

Parent training is a series of interventions based on behavioral orientations that have been demonstrated repeatedly to effectively teach new skills and reduce levels of maladaptive response patterns (Dunlap, Plienis, & Robbins, 1998). Anyone can adopt these procedures relatively easily. With PT, parents can successfully treat a variety of serious behavior problems in natural home and community settings. The behavioral repertoires of children afflicted with ASD are extremely vulnerable to treatment.

Parent training helps change and maintain the ideal behavior in children with ASD. If PT is used with a child diagnosed with ASD and s/he responds well, it is possible to “train” the child with ASD to have acceptable responses to social cues and to teach the child proper social interactions. Because each child with ASD is different, it is difficult to say if PT would be effective with all children with ASD. It is important that parents have a trial run with different interventions until they find one that fits their special child with ASD (Matson, Mahan, & Matson, 2009). It is a difficult but necessary task.

Dunlap, Plienis, and Robbins (1988) emphasize the importance of parent training. After a period of intensive behavioral intervention, children with autism spectrum disorder were either discharged to institutional settings or to home environments in which their parents had received behavioral PT. Follow up measures showed that only those
children who returned to their trained parents maintained their treatment gains or
displayed further improvements. These results not only affirm the importance of
environments but also suggest the longitudinal benefits that may be derived from PT
efforts. Although considerable evidence exists to support the direct and indirect benefits
of parent training as a treatment modality for many families, these results cannot be
generalized for all families with children who have ASD due to the different types of
behaviors that each child with ASD presents (Dunlap, Plienis, & Robbins, 1988).

**Biomedical and dietary approaches to autism spectrum disorder.** There are
no drugs, vitamins, or special diets that can correct underlying neurological problems
associated with individuals diagnosed with autism spectrum disorder. Parents and
professionals have found that some medications used for other disorders are sometimes
effective in treating a behavior associated with ASD but not the disorder itself (Dove,
Warren, McPheeters, Taylor, Sathe, & Veenstra-VanderWeele, 2012; Spencer et al.,
2013). Along with the use of medications, changes to diet and adding certain vitamins or
minerals may also help with behavioral issues (Winburn et al., 2014).

**Dietary interventions.** Some individuals diagnosed with autism spectrum
disorder may have allergies or exhibit low tolerance to certain foods or chemicals. While
these dietary findings are not a specific cause of ASD, food allergies and intolerances
may contribute to the behavioral issues exhibited by these individuals (Winburn et al.,
2014). In recent years, many parents and professionals have reported significant changes
when certain foods and substances are eliminated from a child’s diet. Aside from
allergies and intolerance, some individuals with ASD may have difficulties digesting
proteins such as gluten (Elder, Shankar, Shuster, Therague, Burns, & Sherrill, 2006). Gluten is found in wheat, oats, and rye, and casein is found in dairy products. Some individuals with ASD may not be able to completely break down peptides from foods that contain gluten and casein. The incomplete breakdown and the excess absorption of these peptides may cause a disruption in the regulations of the neurological processes affecting brain functions (Whiteley, Rodgers, Savery, & Shattock, 1999).

Since information regarding the cause of incomplete protein breakdown is unavailable, stopping the intake of these proteins is the only way to prevent further neurological and gastrointestinal damage (Elder, 2003). If a gluten- and casein-free diet is chosen as a method of treatment, it is important that both gluten and casein are not abruptly removed from the diet. Sudden removal may cause withdrawal symptoms. Parents and caregivers should consult with a medical professional in order to ensure that more damage is not being done to the child with ASD (Knivsberg, Reichelt, Hoien, & Nodland, 2003).

**Medications.** A doctor should always be consulted when choosing to use a medication to treat behaviors that may be associated with autism spectrum disorder. Due to the complexity of medications, drug interactions, and the unpredictability of an individual’s reaction to a certain medication, this treatment should never be utilized without consulting a medical professional. A number of medications developed for conditions such as hyperactivity, attention difficulties, anxiety, and impulsivity have been found to be effective in treating symptoms related to ASD (Nickels, Katusic, Colligan, Weaver, Voigt, & Barbaresi, 2008). The goal in utilizing medications is not to cure ASD
but to reduce some of the behaviors that may be impairing the individual’s progress in deficit areas and take advantage of educational and behavioral treatments (Myers, 2007). It is also important that the parents and caregivers of a child with ASD be educated on the potential side effects of the chosen medications.

**Vitamins and minerals.** A few studies among children diagnosed with autism spectrum disorder suggest that intestinal disorders and chronic gastrointestinal inflammation may reduce the absorption of essential nutrients, which may have a tendency to cause disruptions in immune and general metabolic functions that are dependent upon these essential vitamins (Vojdani, Pangborn, Vojdani, & Cooper, 2003). Some individuals diagnosed with ASD may have low levels of multiple vitamins and minerals such as vitamin A, zinc, and magnesium. The most common vitamin supplement used for individuals with ASD is vitamin B. In multiple studies, the combination of vitamin B and magnesium, which is essential in making vitamin B effective, showed improvement in the autistic individual’s eye contact, attention, learning, and behavioral issues (Adams, George, & Audhya, 2006; Pfeiffer, Norton, Nelson, & Shott, 1995). Brain function can also be influenced by different nutrients, possibly aiding in addressing difficult behaviors (Fernstrom, 2000). As with the use of medications, the choice to use vitamins and minerals should be complemented by consultations from a knowledgeable nutritionist or other medical professional and a thorough assessment

**Children with autism spectrum disorder and education.** The Individuals with Disabilities Education Act (IDEA) is a federally mandated program that guarantees free
education to every child diagnosed anywhere on the autism spectrum from the age of three through twenty-one (Jones, 1995). The education provided is determined by the individual’s needs and skill level, whatever the student’s level of functioning may be. These unique needs are thoroughly documented on an Individualized Education Plan (IEP), which is developed by the school staff and the caregivers of the child. If it is the first time that the parents experience an IEP, a comprehensive needs assessment is a great place to start to determine the needs of the child (Jones, 1995). The services provided by the school may include academics, social skills, language, leisure, self-help skills, and behavioral skills.

Parents should play an active role in the decision-making process of their child in order to decide upon the appropriate educational plan (Cooney, Jahoda, Gumley, & Knott, 2006). Parents know their child the best and can provide valuable information to the professionals who will be providing the services. Collaboration between the parents and the professionals is an essential part of helping the child succeed.

**Immigration and Acculturation**

Moving to a new culture can have harmful effects on one’s mental health (Sodowsky & Lai, 1997). Due to the difficulties that acculturation may bring, mental health concerns such as alienation from the majority culture, withdrawal, lethargy, aggression, anxiety (Lynch, 1992), low self-esteem, cultural and familial conflicts, and physical illness (Morrow, 1994) are prone to occur. These difficulties may be temporary, and the way in which they affect individuals undergoing acculturation may differ. Individuals must deal with these issues upon immigration whether they identify with the
host culture or not (Berry, 2004; Phinney, 1990). According to Vedder, Sam, and Liebkind (2007), a strong identification with biculturalism - identifying and connecting with both cultures - contributes to a more positive psychological adaptation. The individual’s identity with their native culture prior to immigration has shown to be related to predicting how they will identify with their new host culture (Tartakovsky, 2009). If biculturalism is not attainable, fostering a strong relationship with the culture of origin is an adequate alternative. The Asian community leans toward separating themselves from the host culture when threat levels from the host culture are perceived as high. When threat levels are low, their need to cling to their own cultural group is less intense. The level of acculturation is an important factor in determining the immigrants’ mental health issues and general well-being (Koneru, Weisman de Mamani, Flynn, & Betancourt 2007).

Learning the language of the host culture also proves to be a challenge for immigrants. In addition to learning the host culture’s social characteristics, obtaining linguistic skills helps the immigrants cope with new issues. Learning the language also lessens the overall negative effects associated with immigration (Neto, 2010). Immigrants are also prone to encountering negative and racially discriminating situations. However small these encounters may be, the collection of these encounters can increase stress, which negatively affects coping skills (Chen & Spencer, 2012; Spencer, Chen, Gee, Fabian, & Takeuchi, 2010). When it comes to Asian Americans, aspects of racism and racist encounters can influence every aspect of their lives including, but not limited to, both physical and mental health (Kim, 2013) which can be negatively affected by their individual experiences. According to Chen and Spencer (2012), first generation
immigrants were physically and mentally better off than those who were born in the United States. For Asian Americans, factors such as income, education level, and generational status can all affect and influence physical and mental health outcomes (Kim & Keefe, 2010).

A lack of adequate social support during the acculturative process adds to the stress and harm on the immigrants’ mental health. Choi (1997) found that having proper social support moderated stress levels, which resulted in fewer symptoms of depression and alleviated acculturative stress. The role of family support clearly is a crucial element in psychological well-being, reducing problem behavior, and buffering the emotional effects of stress (Gore & Aseltine, 1995). Feeling acceptance and being involved with the host culture, in addition to having an adequate social support network has also been connected with better mental health (Thomas & Choi, 2006). Adjusting to the host culture through learning and experience may aid in reducing the stress of the acculturation process. There were two factors mentioned by Kang et al., (2010) regarding Asian Americans and their use of mental health services. Those immigrants with lower language proficiency and those who immigrated later in life, especially after the age of 18, were less likely to partake in mental health services (Kang et al., 2010).

The level of acculturation is also attributed to how much fathers are involved in the parenting of their children (Jain & Belsky, 1997). The acculturation levels of fathers can be attributed to their involvement in fathering, and the more child rearing a father performs, the greater his acculturation. Families who immigrate from a patriarchal culture tend to have more rigid gender roles with fathers working outside the home and
mothers being stay-at-home mothers. These roles may be altered and often begin to erode when acculturating in the United States. Acculturated fathers are more likely to take an interest in being an active part of their children’s lives due to becoming more exposed to the host culture’s way of living and rearing a child (Jain & Belsky, 1997).

**Acculturation and adolescents.** Acculturative stress may cause conflicts in many families, particularly between adolescents and their parents (Thomas & Choi, 2006). Immigrant youth have a tendency to change their cultural identity as time passes (Hitlin, Brown, & Elder, 2006). Parents may misunderstand adolescents when cultural differences, such as social rituals, arise. Parents may compare their children to others in their peer group in terms of discipline and obedience, which can cause distress for adolescents. They may resent their peers because of parental pressure and also feel the need to compete in order to please their parents. During this stress, adolescents from immigrant families who have less social support are more likely to experience higher levels of acculturative stress due to not having someone close to turn to in times of need (Thomas & Choi, 2006).

Some immigrant adolescents may have an idealistic and unrealistic view of the United States due to media portrayals of life in the United States (Kim & Choi, 1994). These adolescents may have high expectations regarding their potential life upon immigrating to the United States. When the high expectations are not met, immigrant adolescents may experience disappointment, resentment, depression, culture shock, and anger. The culture shock is heightened by the incongruence they may experience between the values and goals of their family and those of the host culture (Kim & Choi,
Acculturation can be more of a challenge the later an individual makes this transition.

Another factor for immigrant adolescents that could affect their acculturation is the negative experiences with perceived discrimination from their peers native to the host culture. But according to Neto (2010), adolescents from immigrant families were better equipped to suffer and cope with challenges and were more resilient than those born in the host culture (Herman, 2004). These factors may contribute to the challenges of raising a child within the host culture.

As an adolescent immigrant, learning and utilizing the host culture’s language increases their friendships with native adolescents (Masgoret & Ward, 2006; Serrano & Anderson, 2003). Learning the language also conveys a certain level of acculturation, which makes the adolescent immigrant a more ideal social companion (Caldas & Caron-Caldas, 2002; Gudykunst & Schmidt, 1987). This may decrease the adolescents’ experience with discrimination, which appears to be a bigger problem in schools where immigrants, in general, are not looked at favorably (Brenick, Titzmann, Michel, & Silbereisen 2012). But those who have been discriminated against may have a tendency to avoid the single perpetrator rather than the entire group as a whole that the perpetrator represents (Titzmann, 2014). In general, children of immigrant families often experience psychological stress from a continuing struggle within their peer groups. They may struggle to detach from their own cultural identity and values in order to assimilate, but may also experience pressure from their parents and other adults within their community to conform to ethnic and cultural norms of their culture of origin (Thomas & Choi, 2006).
Adolescents attributed their raised self-esteem and adjustment to having had parents whom they perceived as involved and interested in their lives.

Acculturation has also been linked to improved academic performance (Farver, Bhadha, & Narang, 2002). Studies of immigrant students demonstrated a link between their acculturation levels and their academic success. Students who were more acculturated performed better in school. Acculturating to a school entailed language acquisition, exposure to unfamiliar subject matter, and adjustment to new study habits. The more familiar a student became with the norms and the surroundings of the academic system, the more that student experienced success (Farver, Bhadha, & Narang, 2002).

Although immigration is a difficult transition for both adolescents and adults, the negative psychological and behavioral effects tend to be worse in the first few years after arrival and appear to return to normal levels (Lu, 2010). As with any adjustment, the process of acculturation takes time and appears to get better over time (Titzmann, Silbereisen, & Mesch 2014).

**South Koreans**

Research regarding the adjustment of South Korean immigrant parents is very recent (Mash & Wolfe, 1999). Due to the lack of research regarding this population, it makes it difficult for clinicians and other professionals within the helping profession to provide adequate and necessary services to South Koreans immigrants. The next four sections will review the existing literature on South Koreans, acculturation, and their views on mental health.
South Koreans in the United States. When immigrants from Korea relocate to the United States, they are typically isolated from their emotional and social support systems provided by their networks of friends and relatives in their native country (Jo, 1999; Kim, 1997; Min, 1998). The majority of participants in Min’s study reported that they maintained closer kin contact in the United States than they did in Korea. Family assistance was reported to be the most important source of support and help for psychological, emotional, spiritual support, and immigration orientation (Min, 1998). For Koreans, relatives were found to be equally as important as friends. The lack of social and support networks leads to social isolation and stress, particularly when the immigrants encounter difficult situations (Hong, 1989; Shon & Ja, 1982). Immigrant families were more likely to rely heavily on the social support of the extended family rather than that of friends, neighbors, coworkers, or professional agencies for minimizing risks involved in the long-distance migration and assisting in personal problems (Al-Issa & Ismail, 1994).

Social support has been viewed as a fundamental need and resource which enhances personal security and mental well-being for the South Korean population. Having social support and confiding relationships tended to modify the effects of the immigration trauma experiences on mental health, such as war experiences and grave financial difficulties (Al-Issa, 1997).

The Korean culture is strongly based on Confucianism, which emphasizes filial piety, family ties, and the patriarchal family order (Min, 1998). However, American culture is based more on individualism (Jo, 1999; Kim, Sawdy, & Meihoefer, 1982).
Therefore, when family conflicts arise within immigrant families, it is imperative to take into consideration the gap in acculturation. While considering this factor, demographic and mediating variables such as family value systems and their social support systems between immigrant parents and their American raised children also have to be taken into consideration (Lee et al., 2000).

Due to the Confucian influence, women are still believed to lack marketable skills regardless of their educational achievements. Even in today’s Korean economy, college educated women experience significant under employment and unemployment in Korea’s economy (Kim, 2005). Since educated women have difficulties in the work force, women tend to focus more on child rearing and their child’s achievements as they are more rewarded by their child’s achievements than their own (Kim & Ryu, 1996). Due to the emphasis that is placed on the child’s achievement, mothers carefully manage their child’s academic success and tutors are commonly hired to give their child an advantage (Cho, 1998; Hur & Yoon, 1998). Also based on Confucian beliefs, South Korean children are still expected to conform to their elders and the children expect themselves to as well (Yang, 2009).

According to the literature, Korean American adolescents and young adults experience conflicts with their parents in working through acculturation issues and ethnic identity problems (Kim, 1997; Min, 1995; Moon, Wolfer, & Robinson, 2001). Research has shown that less acculturated individuals tend to exhibit more conflict than acculturated individuals (Padilla, Wagatsuma, & Lindholm, 1985; Salgado de Snyder, 1987), express dissatisfaction with life (Wong-Rieger & Quintana, 1987), exhibit

**South Koreans and mental health.** In the West, psychotherapy is a significant component in the quest of well-being by individuals and collectivities (Wong & Tsang, 2004). In the East, psychotherapy is a new school of thought and there is still a stigma in seeking mental health treatment (Jo et al., 2011). Although it has been available, it has not been utilized frequently as it has in the American population. Seeking professional help to deal with new and/or difficult experiences is acceptable and often recommended when in the United States. For the South Korean immigrant population, this choice does not come so naturally for a variety of reasons such as social stigma (Shin, 2002).

As an immigrant to a new country, it is difficult to predict the feelings and emotions that one might experience with the new endeavor. Many perceive the Asian populations to be unemotional individuals due to not readily showing their emotions. Emotions are not made public when experienced and will-power is utilized in order to overcome hardships (Kim, 1997). Although emotions are not made public, in a study completed by Han and Grogan-Kaylor (2012), it was found that the level of warmth, caring, understanding, and affection shown to children promoted self-esteem, protecting them from mental health issues. Similarly, parenting behaviors, like monitoring, was also associated with positive self-worth communicating to the child the responsiveness and closeness of their parent (Han & Grogan-Kaylor, 2012; Garber, Robinson, & Valentiner,
Parental monitoring was also found to decrease aggression in children (Han & Grogan-Kaylor, 2012) by not giving the adolescents a chance to engage in negative behaviors since the parents were aware of their whereabouts (Pettit, Laird, Dodge, Bates, & Criss, 2001). Emotions may be kept from the public, but South Korean parenting practices have shown to decrease mental health issues through other forms of parenting styles.

**Lack of utilization of mental health services.** For the Asian American population, utilization of services and seeking help is much lower than their U.S. counterparts as well as other racial and ethnic groups (Chu & Sue, 2011). This, however, does not mean that there is a lower need. Many Asian Americans have a tendency to avoid mental health agencies and other public services due to the record of their problem resulting in public knowledge which may bring shame to their family. According to Abe-Kim et al. (2007), the second generation of immigrants or children of immigrants, were similar in their help seeking behaviors when compared to their parents, first generation immigrants. When it came to the third generation, their behaviors were closer in similarity to the host culture.

Reasons for the lack of utilization of mental health services for South Koreans may be due to certain social stigmas. Members of the South Korean immigrant community believe that seeking therapy may carry a negative stigma not only for the client but also for the family (Johnson & Nadirshaw, 1993). For example, community awareness of a client’s mental health status may decrease the individual’s chances of marriage as well as potentially lower the family’s status in the community. People with
developmental disabilities are regarded with superstition and prejudice, and the causes of these disabilities were attributed to ghosts, punishment for bad behavior of ancestors, or bad thoughts (Fan, 1999).

Another reason for the lack of utilization of mental health services may be due to the South Koreans expressing their psychological distress through somatic symptoms. As a result, a common stereotype has developed amongst mental health professionals that the Asian population is not psychologically minded and the individuals lack the capacity for insight necessary for certain talk therapies (Johnson & Nadirshaw, 1993). There is, however, no conclusive evidence that the Asian population experiences more somatic symptoms than any other ethnic group (Yeh, 2003).

The reluctance to engage in self-disclosure may be another reason for lack of utilization. Participating in a therapeutic relationship requires self-disclosure. Self-disclosure is defined as revealing personal information about oneself to others (Barry, 2003). The norms of self-disclosure differ considerably between the Asian and American cultures. For example, Chinese individuals are significantly less likely than Americans to reveal personal information to strangers, acquaintances, parents, or intimate friends (Chen, 1995). The varying degrees of self-disclosure may be attributed to demographics and culture. Other explanations may involve ethnic identity, acculturation, and gender differences (Barry, 2003).

There is a common misperception among mental health professionals that the members of the Asian immigrant population do not really suffer from developmental disabilities or mental illness due to the lack of utilization of mental health services.
Mental health professionals believe that any problems that are experienced, are contained and addressed within the family (Johnson & Nadirshaw, 1993).

The underuse of mental health services by Asian immigrants will not be resolved unless restructuring of the mental health service system is linked to more efficient service delivery (Shin, 2002). It is vital that the services be made readily available for the Asian population, as the individuals do not seek it out. The delivery of services need to be made present in the places that the Asian population most feel comfortable such as churches, doctor’s offices, and other community gathering locations. The design of interventions may help to be more comprehensive and connected with the needs of the population whether the target is low-income, multiethnic, or newly acculturating populations (Tien, 1992).

Increasing the availability of therapists who speak the client’s native language and understand how to be culturally competent are important factors in keeping reluctant clients in treatment once they have sought help (Chu & Sue, 2011). These trained therapists need to have an understanding of cognitive styles, coping skills, goals, and perception of the problem from their views, in order to provide a safe environment and connectedness with the client (Zane et al., 2005). Also, collaborating with other professionals who provoke less stigma within the Asian American population, such as acupuncturists and holistic healers, may also be another route to offer more services to this group.

Current mental health services are often unresponsive and inappropriate in providing mental health care to ethnic minority populations (Ettner, 2001). Therapists
who identify strongly with the Western culture emphasize independence, self-sufficiency, and self-control rather than harmony, mutual support, and sensitivity to others, which are hallmarks of the Asian culture (Shin, 2002). The treating therapist must consider alternatives that the client may be seeking such as herbal medicine, acupuncture, holistic therapies, etc. in order to help address his/her current mental ailments (Jo, 1999). In order to understand fully the client’s personal and cultural beliefs about the effectiveness of treatment, these branches of medicine and methods of treatment must be explored.

Help-seeking behavior. The continuing existence of significant underutilization of mental health services and delayed treatment among Asian immigrants highlights an urgent need for a broader understanding of their help-seeking behaviors (Shin, 2002). Lin, Inui, Kleinman, and Womack (1982) found that the help-seeking process was correlated strongly with ethnicity. Asian Americans tended to show a longer delay for treatment when ill than did African Americans and Caucasians.

Shin (2002) found that men had greater difficulty utilizing mental health services as compared to women. Women were more likely than men to recognize potential psychiatric problems, discuss these problems with other people, and enter treatment voluntarily. On the contrary, men appeared to isolate themselves from receiving information about their potential conditions and the existence of mental health professionals, and were more likely to deteriorate to the point that their behaviors became strange enough for others to initiate treatment (Shin, 2002).

The Asian immigrant population may also have difficulty locating a mental health provider due to lack of knowledge of services and providers available. They may also
doubt the effectiveness of treatment and fear the reliability of confidentiality. In the Asian community, the group’s well being is much more important than that of the individual. It may be problematic if the community becomes aware of the client’s need to seek professional help (Johnson & Nadirshaw, 1993).

According to Shin (2002), the mean duration of the interim between the onset of the problem and first psychiatric consultation among psychiatric service users was 5.3 years. These factors of familial shame, seeking out alternative treatment, and other culturally driven decisions led to a delay in contact with mental health services and entry into treatment (Shin, 2002). Understanding cultural and social factors that affect help-seeking behaviors is important because these factors may be deterring or delaying some immigrant populations from receiving timely, appropriate mental health care (Shin, 2002).

When the difficult decision is made to seek help, the South Korean and other Asian populations prefer to contact nonprofessional sources like on line support, healers, traditional holistic medicine, or even medical professionals (Chu, Hsieh, & Tokars, 2011). Because seeking help for mental health issues could be an anxiety provoking experience, about a third of Asian Americans will drop out of treatment before the intake session has even taken place making premature termination a common issue (Akutsu, Tsuru, & Chen, 2004). For Vietnamese Americans, like South Koreans and other Asian populations, the decision to seek treatment is a complex process involving increased somatic symptoms, language, disruptiveness of mental health issues, age, and other emotional factors (Nguyen, 2013).
Asian immigrant clients may seek therapy as a last resort for their mental ailments or may be forced to attend by school counselors or law enforcement if the client has been in trouble with the law. Many social service providers in Asian communities, such as social workers, fear that they will lose their clients if they mention the need for psychiatric services. As a result, formal service providers do not take an active role in helping their clients to receive timely, appropriate psychiatric care (Shin, 2002). Geographic location may also be a factor with the Asian population. Due to the social stigmas attached to mental health, clients may prefer to travel away from their communities to places where they may not be identified. Bicultural and bilingual mental health providers may be able to do this work more easily as they may be more sensitive to cultural issues and may be able to communicate with immigrants in their native language (Shin, 2002). The movement toward identifying culturally sensitive and relevant solutions to close the gap between Asian Americans and mental health services, quality of care, and treatment outcomes remains a focus in Asian American mental health research (Chu & Sue, 2011).

**Perceptions of Children with Disabilities and Impairment**

Having a child with a disability is stressful and learning to adjust to having a child with a disability can be an even bigger challenge. Negative beliefs and stigmas regarding disabilities may have decreased over time but still remains an issue (Brown, Ouellette-Kuntz, Lysaght, & Burge, 2011; Rice, 2009). These stigmas can affect the self-esteem of individuals with disabilities and also hinder the inclusion process (Ali, Strydom, Hassiotis, Williams, & King, 2008). Some believe that individuals with disabilities can
participate as full members of society having a positive attitude toward them (Morin, Rivard, Crocker, Boursier, & Caron, 2013) while others continue to discriminate against them. This section will review the differences in perceptions of those biologically unrelated to individuals with disabilities and parents’ experiences and perceptions of their child with a disability.

**Perceptions of education and mental health communities.** Research indicates that both children and adults have a more positive attitude toward persons with physical disabilities than toward those with developmental or psychiatric disabilities (Ashman, 1984; Furnham & Pendred, 1983; Woodward, 1995). Individuals with psychiatric disabilities are often perceived as being uncivilized, child-like in their behaviors, and dependent on other people for needed assistance (Sze & Valentin, 2007). Individuals with disabilities may also be viewed as a source of entertainment for those without disabilities because socially acceptable behavior may be difficult for them.

Learning and mental health disabilities are less visible than physical disabilities and have a more difficult time being accepted and understood when unwanted behaviors are displayed. Martinez (2006) reported that students with multiple learning disabilities may experience poorer parent, classmate, and friend support as compared to those students with a single physical disability. Overall, students with any type of developmental disabilities or physical disabilities are more often rejected by their peers than students without (Hatzichristou & Hopf, 1993).

**Teachers.** Teachers suspect that behaviors of children with disabilities could overtly isolate the child in the classroom. Teachers also reported that boys with
disabilities experienced significantly more psychological problems than girls (Masten, Morison, Pellegrinin, & Tellenge, 1990). Boys were also more prone to externalize or express their emotions physically as compared to girls.

When teachers were asked about their abilities to recognize mental health issues in children, they reported that the internalizing behaviors, such as sadness and withdrawal, were easier to identify than externalized behaviors (Williams, Horvath, & Wei, 2007). The majority of teachers stated that they were too busy and preoccupied with externalizing behaviors to address the possible mental health issues. Other teachers were confident in identifying externalizing behaviors and believe that parents and caregivers are crucial components in decreasing the teachers’ lack of understanding of their children’s disabilities (Farnfield & Kaszap, 1998).

In a recent study completed in Japan (Kayama & Haight, 2014), the educators helped guide the parents to overcome stigma and to accept their child with a disability. Both educators and parents described having “henken”, a negative biased view or stigma, toward individuals with disabilities. Henken can also result in parents feelings shame regarding their child’s differences (Kayama & Haight, 2014). Japanese educators believed that the parents’ attitudes regarding their child’s disability had a direct impact on how their child performed in school.

Due to the cultural differences, the educators had difficulties getting the parents involved as the parents were more concerned with the stigma and sensitive to other people’s opinions. However challenging, Japanese educators were dedicated to involving the parents and getting them to accept their child openly. Their focus was on relationship
and partnership building, communication, and emotional support (Kayema & Haight, 2014).

Although there were obstacles to addressing disabilities within the school setting, teachers also perceived parents to be significant barriers to mental health services and treatment (Williams, Horvath, & Wei, 2007). Teachers reported that parents often did not follow up on the suggestions such as agencies to contact for treatment. Teachers perceived that parents expected the school to have all the answers regarding childhood mental health and resolve their problems. As a result of this expectation, teachers reported feeling disrespected by the parents. Some teachers did, however, identify parents as being strong supporters but these parents also sought other personnel to aid them with the disabled students, such as counselors and support of teachers (Williams, Horrath, & Wei, 2007).

Mental health professionals. When it came to working with children with mental health issues, mental health clinicians felt less competent, knowledgeable, and skillful in child and adolescent mental health as compared to working with adults (Cockburn & Bernard, 2004). Children’s mental health service providers and researchers agree that family involvement is an important factor in effective treatment. In order to further promote this factor, professionals’ interactions with families appear to be primarily aimed at changing bad parenting or family dysfunction. Culturally appropriate practice models that incorporate an understanding of the historical and cultural context of different groups, as well as their implications for services and families, should be broadly disseminated and implemented (Friesen, 2007).
Perceptions of parents. When a child with a disability is born, parents process it at different rates with varying emotions. Most parents experience an increased level of stress (Hallberg, 2014) due to the increase in responsibilities (Brennan & Brannan, 2005; Deater-Deckard, 2004). According to Lawson (2006), parents are more likely to terminate a pregnancy following a prenatal diagnosis for either a physical or a developmental disability such as muscular dystrophy or Down syndrome as compared to parents with babies developing within the normal range. It is perceived that parenting a child with Down syndrome is viewed as less personally rewarding, but not inherently more costly, than parenting a child with a physical disability (Lawson, 2006). Parents of children with Down syndrome also tend to have stress levels comparable to parents of typically developing children (Blacher, Baker, & Kaladjian, 2013; Povee, Roberts, Bourke, & Leonard, 2012). They also seem to be better off, stress wise, when compared to parents of autism spectrum disorder and other disabilities (Gerstein, Crnic, Blacher, & Baker, 2009). It is the potential loss of anticipated parenting rewards, rather than the expectation of heightened costs, that influence parenting decisions (Lawson, 2004). Parents of children with disabilities may require additional support or intervention to address their own psychological worries regarding the future (Esbensen, Seltzer, & Greenberg, 2006).

Parents of children with developmental disabilities face challenges that vary with the nature of the child’s disability (Ricci & Hodapp, 2003). Parenting stress is defined as the pressure parents experience that stems from their interactions with their children (Abidin, 1990). Parents of children with disabilities face significantly higher levels of
pressure to provide and are more likely to feel hopelessness and fear regarding their child’s condition and treatment as compared to parents of children developing typically (Lee, Chen, Wang, & Chen, 2007).

Parents of children with emotional and behavioral disorders experience difficulties and strains as a result of providing care for them. These difficulties include financial strain, disruptions in social and family relationships, interruptions at work, sadness and guilt, and other negative effects (Brannon, 2003). The stress that parents experience affect other family members when they are unable to adequately process their stress related emotions and actions (Brannon & Heflinger, 2001). The strain on parents depends on the degree of symptoms and levels of functioning of the child needing care (Angold, Messer, Stangl, Farmer, Costello, & Burns, 1998). When children’s symptoms improve over time, so does caregiver stress (Brannon & Heflinger, 2001).

Family members respond to the added pressures and stresses of caring for a child with mental health needs in different ways and experience strain at different levels. Caregivers' stress has been directly correlated with when a child enters treatment and which services are received and utilized (Farmer, Burns, Angold, & Costello, 1997). Some services and treatment require more attention from parents or a more intense approach. Caregivers’ stress has also been associated with hospitalization, length of time in treatment, inpatient stay, and other factors (Foster, 1998). Caregiver stress may be more potent than other family variables, such as demographics or psychological distress in predicting use of children’s mental health services. It may contribute to the prediction of service utilization patterns (Brannan, 2003).
Once parents began to notice a developmental difference in their children as compared to peers developing typically, parents struggled to understand and figure out what had happened to their children and gain information about what was wrong. Parents reported that the information provided by professionals was inadequate and confusing (Howard, 1994). They requested more, accurate, and repeated information in order to understand and retain what they had learned (Scharer, 2002). Parents also stated that accurate and timely information was crucial in maintaining trust between providers and parents. Some parents reported feeling dismissed, ignored, and powerless when interacting with professionals (Babb, 2007). Other parents reported having unmet needs in the areas of services and supports such as inclusion opportunities for their child, advocacy, and education (Freedman & Boyer 2000).

When the parents finally come to an understanding of their children’s developmental disability, the feeling was described as shock and disbelief accompanied by feelings of confusion, anger, and despair (Pejlert, 2001). Some parents described experiencing the loss of their child as a mental loss, which can lead to depression and conflict in some families. This loss involves more than grief for some parents (Babb, 2007). Parents perceived the diagnosis of ASD as a loss of their child, not in the physical sense, but in the mental and emotional relationship. Parents who had multiple children, including special needs, had more difficulties as their normally developing child was a constant reminder of their loss. Parents described accepting the diagnosis but not the consequences that followed.
In an article written by Scharer (2002), the parental needs of children with developmental disabilities were outlined. Parents reported wanting a discharge summary or hospital records, as well as information about the hospital unit for children needing to be hospitalized. Parents also reported that the amount of stress experienced during the time of hospitalization may have hindered their ability to recall what they were told. Parents expressed the desire for more guided support and punctual adherence to appointments. They perceived hospitals to be unwelcoming and felt that some staff were not invested in their jobs. The parents reported feeling isolated and under-supported due to their child’s developmental disability.

Caring for a child with a developmental disability is a source of psychological distress, with mothers of special needs children being at a greater risk than mothers of children with typical development (Dyson, 1996; Hintermair, 2000; Hoffman, Sweeney, Hodge, Lopez-Wagner, & Looney, 2009). Parenting stress levels are higher in mothers whose children receive special education as compared to those with children not enrolled in special education (Lee, Chen, Wang, & Chen, 2007). Pearson and Chan (1993) reported that parenting stress in mothers with disabled children showed that social support works as a catalyst for building up a greater defense system against the effect of unpleasant surprises along the way. Finding emotional support from spouses and social environments was reported as one of the most difficult tasks for parents (Hallberg, 2014; Pearson & Chan, 1993).

According to Schieve et al. (2011), mothers of children with developmental disabilities had higher levels of anxiety and depression than mothers of typically
developing children. Mothers of youth with Down syndrome generally displayed higher levels of well-being as compared to mothers of youth with other developmental disabilities. On the other hand, mothers of youth with ASD fared very poorly when compared to mothers raising children with other forms of developmental disabilities (Lewis et al., 2006). Mothers of children with fragile X syndrome displayed relatively high levels of parenting stress (Sarimski, 1997) and low levels of psychological satisfaction displaying more depressive symptoms when compared to mothers of children with Down syndrome (Lewis et al., 2006). Esbensen, Seltzer, and Greenberg (2006) found that the degree of depressive symptoms of the adult child with developmental disabilities was predictive of maternal depressive symptoms and pessimism about the child’s future, but not predictive of the maternal perception of the quality of the parent to child relationship.

Many parents perceived that children with developmental disabilities are isolated from other children and consequently have difficulties and fewer opportunities to engage with others. These difficulties may keep these children from engaging in play with peers and developing functional peer relationships (Markham & Dean, 2006). Parents believed that education and awareness of developmental disabilities were important for peers developing within the typical range in order to understand a disabled child's development and diffuse difficult situations. Some parents commented on their children’s anxiety, frustration, and low self-esteem stemming from academic performance to social interactions (Markham & Dean, 2006).
According to Bristol (1984), parents’ perceptions about receiving adequate social support for themselves and their children have been correlated with successful family adaptation. Social support has been defined as feeling cared for and loved, valued and esteemed, and it is important in a network of mutual obligation and communication (Cobb, 1976). Examples of social support include support from one’s spouse, family and friends, community programs, professionals, and the availability of leisure time (Siklos & Kerns, 2006). A stronger indicator of healthy adaptation and coping in the family was the amount of perceived support the mother received from her spouse. Social support, or the perception of social support, can also decrease the impact of stress on depression in mothers of children with ASD, indicating that social support plays an important role in maintaining the mental health of these parents (Fisman & Wolf, 1991; Minnes, Perry, & Weiss, 2014).

According to Scharer (2002) and Hastings (2002), some parents reported that keeping a continued positive outlook on their future and the future of their child helped them to cope. In addition, becoming an advocate for their child or for children with developmental disabilities in general aided as a coping mechanism for parents (Scharer, 2002). Parents of children with developmental disabilities were seen as trusted sources of information as compared to teachers. In order to advocate properly, parents needed accurate information regarding their children’s developmental disability, diagnosis, prognosis, treatments, and their own appropriate roles (Scharer, 2002).

Stephenson (1992) found that parents of children who were learning disabled felt that planning for the future, receiving services and having parental rights and
responsibilities were all important concerns. Many reported having good experiences with individual doctors and therapists by participating in their child’s treatment and if clear and definite boundaries between effective and ineffective treatments were drawn. Parents also reported that they valued therapy that was focused on specific problems and that stressed change in behavior rather than development of insight (Stephenson, 1992). Parents believed that few doctors or therapists understood the special problems of children with developmental disabilities.

Perceptions of South Koreans. In South Korea, individuals with any type of disabilities are stigmatized and viewed as a threat to the family (You & McGraw, 2011). Many Asian people hold stigmatized attitudes toward developmental disabilities and people with these disabilities (Fan, 1999). Descriptions of the developmentally disabled population from the media contribute to clients avoiding services as they may be viewed as violent, dangerous, and pathetic (Shin, 2002). The Confucian belief requires the children to care for their elders and give respect. Koreans believe that having any type of disabilities hinders their abilities to care for and pay respects to their elders properly (Lee, 1998). Some believe that disabilities occur because the past generations chose inappropriate grave sites for family members or did not take proper care of their elders’ grave sites (Kim & Kang, 2003). Individuals with any type of disabilities are undervalued in Korea due to the shame they bring to their families by not conforming to the ideals of academic and monetary success. Although some developments have been made toward improving the lives of those who are disabled, it continues to be stigmatized as shameful (Kim, 2002).
Apart from the stigma associated with developmental disabilities, others explained the Asian community’s underutilization of mental health services in terms of their lack of English proficiency, knowledge, information, financial resources, and fear of social demotion (Pearson & Phillips, 1994; Shokoohi-Yekta & Retish, 1991). There may be a conflict between Asian cultural beliefs and values as compared to modern psychotherapy. Modern, Western-style counseling and psychotherapy deem development of the individual self as the essence of mental health (Nash, 1993). Even second-generation Asians who have acculturated may be reluctant to abandon family traditions, obligations, and loyalty to advance self-centered interests (Das & Kemp, 1997).

**Parents’ experiences with children who have autism spectrum disorder.**

Autism spectrum disorder is a severe developmental disability that presents a particularly difficult challenge for a family unit (Dewey & Kaminsky, 2002). This disorder has a different impact on every person affected. There is existing research regarding parents’ experiences with children who have autism spectrum disorder.

Parents experience a significant amount of stress when a child with autism spectrum disorder is added to their family (Dunlap, Plienis, & Robbins, 1988). When parents have a child with autism spectrum disorder, parental stress can be attributed to the child’s behaviors, lack of support both professionally and personally, and the social stigmas along with the lack of understanding (Pisula, 2011). Many scholars and investigators are deeply concerned about the detrimental effects of blaming parents for their child’s ASD, finding this positioning to be pejorative (Russo & Newsom, 1982), if not harmful (Rimland, 1964). Regardless of etiology, the presence of a child with ASD is
a significant source of stress that may affect some aspects of parental adjustment and family functioning (Dunlap, Plenis, & Robbins, 1988).

Regardless of the severity of the diagnosis, parenting a child with ASD has a negative effect on not only the parents but the family as a whole as well (Pottie & Ingram, 2008). Stress related to having a child with ASD typically begins before a formal diagnosis is received, usually beginning around when differences in social behaviors, play, communication, and motor skills are first noticed (Bolton, Golding, Emond, & Steer, 2012). Once a formal diagnosis is received, parents feel a sense of relief having been given a concrete answer to address their child’s differences. But 63% of parents surveyed, shared great dissatisfaction with the way in which the diagnosis was delivered to them (Chamak, Bonniau, Oudaya, & Ehrenberg, 2011).

Parents of children with autism spectrum disorder reported experiencing difficulties from different agencies, such as public health, when compared to the parents of the typically developing children (Konstantareas & Homatidis, 1989). Parents of children with ASD reported a consistently greater need for therapy for their children, and a need for professionals who are knowledgeable about autism spectrum disorder (Siklos & Kerns, 2006). Parents of children with ASD often hope that intensive intervention can lead to a cure or a significant improvement in their children’s behaviors.

Adjustment. Once the parents have passed through the initial stages of grief, asked questions, and finally accepted the reality of the challenges of having a child with ASD, it is important for the parents to understand the special education and the system in which their child will be involved. Advocating for their child with ASD presents a new
reality to parenthood, one that was not planned for or expected (Foster, Rude, & Grannan, 2012). Due to the unexpected surprise, it often leaves parents with more questions than answers.

The psychosocial adjustment of parents who have children diagnosed with autism spectrum disorder can be best compared to the parents of typically developing children. Therefore, parental maladjustment as a contributing factor to the cause of ASD can be confidently ruled out (Dunlap, Plienis, & Robbins, 1988). The three most severely affected areas due to the diagnosis of ASD were family recreation, finances, and the emotional and mental well being of the parents. Interpersonal relationships within the immediate family, extended family, and community were also affected by the high demands and difficulties in raising a child with ASD (Dunlap, Plienis, & Robbins, 1988). The financial burden alone would cause a lot of stress. In order to raise and care for a child with ASD, Sweden estimated in 2005 that it would cost about $70,000 U.S. dollars a year (Stabile & Allin, 2012).

Once a child is diagnosed with autism spectrum disorder, there is an inevitable shift in focus by the mother who naturally becomes more focused on her child as opposed to her career. In a recent study, it was found that two-thirds of parents in a two parent household reported that the mother’s work outside of the home was the most negatively affected by having a child diagnosed with ASD (Schuster, Chung, & Vestal, 2011). In another study by Baker and Drapela (2010), it was revealed that of the employed mothers who had a child diagnosed with ASD, more than half of those mothers worked fewer hours to care for their child. A quarter of the mothers who participated in this study
shared that they took a leave of absence and another quarter admitted to turning down promotions in order to care for their child diagnosed with ASD. To further support this switch in focus, another study found that mothers who had children with chronic medical needs, including the use of technical devices, were much more likely to leave their jobs entirely in order to care for their child (Thyen, Kuhlthau, & Perrin, 1999). When it came to work, the parent who experienced higher levels of parental stress benefitted more from working outside the home as a form of respite as compared to parents who experienced less stress (Morris, 2014).

Mothers who had a college education and were dedicated to their careers shared a considerable amount of dissatisfaction and frustration with their inability to both manage their careers and care for their child’s needs (Home, 2004). When mothers of children who had disabilities were compared to mothers of typically developing children, it was found that mothers of children who had disabilities shouldered a disproportionate burden of care (Cohen & Petrescu-Prahova, 2006). Having a career offers individuals contact with other adults, individual identities, and the ability to participate in non-parental activities (Scott, 2010). Due to the many offerings that a career has to offer, not working has a tendency to increase social isolation, which can contribute to emotions such as depression and despair (Shearn & Todd, 2000).

Joint attention, both parents giving the child attention, may be one of the hardest things to achieve with a child who has autism spectrum disorder due to the child’s inability to reciprocate social cues to two individuals and respond appropriately, among other deficits (Mash & Wolfe, 1999). In children with ASD, a developmental link exists
between parental sensitivity and the child’s subsequent development of communication
skills (Sigman and Siller, 2002). It was found that caregivers who showed higher levels
of coordination during initial play interactions had children who responded better in terms
of joint attention and language over a period of time (Sigman & Siller, 2002). Although
joint attention is difficult to achieve with a child who has been diagnosed with ASD, it is
important that the parents do what they can to engage with their child. This is one of
many interventions that can be used with a child who has ASD.

According to Capps, Kasari, Sigman, and Yirmiya (1993), parents’ perceptions of
their children with autism spectrum disorder differed from general research stating that
children with ASD were affectively flat. In their study, parents did not view their child
with ASD as affectively flat but rather perceived them to be highly expressive,
particularly of negative emotions, whereas typically developing children were perceived
as more expressive of positive emotions (Capps et al., 1993). Adjustment would be made
significantly easier if researchers were able to identify the needs of these parents and
siblings. It would help to give the families a chance to commiserate and relate to other
families who may be experiencing similar situations.

*Coping.* Parents of children who have been diagnosed with autism spectrum
disorder find comfort in helping others. Parents who have children with ASD have come
together to utilize the internet in which they are able to help each other in their own
distress and despair. The internet allows such parents to create virtual support groups
that extricate them from their isolation and counter the sense of powerlessness that can
arise in such circumstances (Fleischmann, 2004). The internet has allowed parents to
create a valuable networking system if not a complete virtual community. Writing about emotionally-loaded experiences can help individuals work through and overcome emotional problems (Pennebaker & Seagal, 1999).

In a study completed by Sayyedi, McConkey, and Kelly (2012), a short, family-centered class for parents who had children with autism spectrum disorder was found to have a positive influence on parental perceptions of their emotional well-being, stress, and functioning. The participants in this study appeared to keep these positive changes with them up to three months after the course was over. Some factors that accounted for these changes were further learning about autism, asking questions, building social networks, and applying what they learned to their own child. Parents who attended these types of groups and other sources of support shared that the presence of other parents was useful which supports the study that stated that professionally led support groups were more successful and increased parental self-efficacy as compared to video based learning (Keen, Couzens, Muspratt, & Rodger, 2010).

Harris, Weitz, and Wolchick (1981) found another intervention teaching the child with autism spectrum disorder language skills to help with parental coping and adjustment. It is noted that children with ASD can make substantial gains in pre-speech and speech skills after their parents have been trained in the techniques for teaching these skills. If this speech training is taken in conjunction with Parent Training, there may be significant changes in the child’s speech and behavior.

Another aspect of coping and adjustment was the facet of religion. The literature reported that attributions to fate or God’s will were related to better adjustment while
coping with difficulties (Mickelson, Wroble, & Helgeson, 1999). The literature also stated that religiousness, generally speaking, was more closely and consistently linked to active coping (Pargament & Raiya, 2007). Religious beliefs can shape a person’s psychological perception of pain or disability as it creates a mindset that enables the person to relax and allows healing on its own (Joshi, Kumari, & Jain, 2008). Religion can play a major role and can provide hope in despair.

According to Undersood and Teresi (2002), participants were able to find hope and experience deep peace even in the midst of mental distress through religion. In a study completed by Joshi, Kumari, and Jain (2008), the religious participants found that engaging in positive religious coping behaviors was helpful. These behaviors include trying to find a lesson from God in the stressful event, doing what one can do and leaving the rest in God’s hands, seeking support from church members, thinking about how one’s life is part of larger spiritual force, looking to religion for assistance to find a new direction for living when the old one may no longer be viable and attempting to provide spiritual support and comfort to others.

The literature also suggested that having religion as a coping mechanism could negatively impact the individual since their blind faith would not prepare them for real situations and hardships. Ellis (1980) had claimed that religiousness was accompanied by irrational thinking and emotional disturbance while Gartner (1996) found religion was associated with some forms of psychopathology, including authoritarian, rigidity, dogmatism, suggestibility and dependence. Negative religious coping includes passive waiting for God to control the situation, redefining the stressor as a punishment from
God, or as an act of the devil, and questioning God’s love (Pargament, Koenig, Tarakehwar, & Hahn, 2004; Tepper, Rogers, Coleman & Malony, 2001).

The literature stated that other parents were cited as the most common source of support, surpassing spouses, family members, friends and neighbors, written sources such as books, web pages, and religious communities (Mackintosh, Myers, & Goin-Kochel, 2005). An existing piece of literature studied mothers coping with their child who were diagnosed with autism spectrum disorder finding religion to be an important method of coping. But more recently it was found that the feelings of belonging felt by the parents was more helpful as a coping mechanism (Kuhaneck, Burroughs, Wright, Lemanczyk, & Darragh, 2010).

**Mental health and other issues.** Diagnosis of a child’s autism spectrum disorder constitutes a turning point for parents. In the wake of the diagnosis, most parents gird themselves to take action, which in turn leads to a more positive perception of their own efficacy and a more positive perception of their child (Fleischmann, 2004). Despite physical, mental, and emotional stress experienced by parents of children with ASD as reported above, Montes and Halterman (2007) found that mothers of children with ASD had higher levels of closeness in their relationship with their child when compared to mothers in the general population. Along with this finding, Hoffman et al. (2009) found that the ASD diagnosis acted almost like a protective barrier between the parent and the child allowing the parent more understanding of their child’s behaviors and shortcomings. Montes and Halterman (2007) agree that parents of children with ASD,
although frustrated by their behaviors, were less likely to become angry with their children.

A delay in diagnosis may result in parental distress. Prior studies indicated that parents of children with ASD are liable to encounter difficulties in functioning and suffer from depression (Lainhart, 1999; Chase, Landa, Piven, & Wzorek, 1991). Another study concurred with these findings and indicated that a change of perception on the part of the parents following diagnosis can enhance the ability of the parents to adjust and cope (Midence & O’Neill, 1999). The research demonstrated that as a result of personal change following diagnosis, parents view coping with ASD as a positive challenge of empowerment (Fleischmann, 2004).

Some parents of children with autism spectrum disorder attributed the cause of the disorder to heredity and environment (Helgeson, Mickelson, & Wroble, 1999). Self-blame attributions and attributions to the environment were related to worse adjustment; whereas attributions to fate or God’s will were related to better adjustment. Helgeson, Mickelson, and Wroble (1999) found that parents’ attributions corresponded with the available scientific literature, and noted that they may change over a period of time. These attributions were also related to stressors. Parents of children with ASD may have reactions such as shock, guilt, and despair which all cause stress as related to their child. Parents who responded positively to these emotions may have reached an adjustment in each of these areas (Blacher, Eden-Piercy, & Eyman, 1986).

Maternal depression as it relates to the diagnosis of autism spectrum disorder is another factor that may affect parental adjustment. In a study conducted by Bristol,
Gallagher, and Holt (1993) the fact that maternal depressive symptoms declined over time in response to an intervention program does not rule out a possible genetic explanation for maternal depressive symptoms in families of persons with ASD. Persons genetically predisposed to a disorder may be more susceptible to environmental stress. To prove that depression is part of the characteristics for ASD, however, it will be necessary to prove not only that maternal depression occurs in families of persons with ASD, but that it is specific to ASD rather than to stressful environments or other disabilities (Bristol, Gallagher, & Holt, 1993).

As far as fathers are concerned, it was found that those with adolescents and young adults with ASD had more depressive symptoms as compared to fathers of young adults with Down’s syndrome or fragile X syndrome (Hartley, Seltzer, Headm, & Abbeduto, 2012). These results suggested that parents of adolescents and young adults with Down’s syndrome, fragile x syndrome, and ASDs utilize similar coping skills to deal with child-related stress but experience varying amounts of stress, depressive symptoms, and pessimism. Parenting challenges and stress related to ASD have been found to be more stressful than parenting adolescents and young adults with Down’s syndrome (Abbeduto, Seltzer, Shattuck, Krauss, Orsmond, & Murphy, 2004). Fathers also tended to engage in more problem focused coping skills as compared to verbal ones such as sharing and talking about their experiences (Hallberg, 2014). Also creating a close relationship with the child diagnosed with ASD helped to decrease paternal stress when compared to mothers (Hallberg, 2014).
Not only does raising a child with ASD produce stress for the parents, it also seems to affect the parents’ general well-being and increase mental health concerns, such as depression and anxiety (Ekas, Lickenbrock, & Whitman, 2010). When comparing parents with a child diagnosed with ASD, anxiety and depression appeared to be worse than parents of typical children and parents of children with other disabilities (Gau et al., 2011). Mental health concerns were not limited to simply depression and anxiety. Taiwanese parents with children diagnosed with ASD experienced mental health issues such as obsessions and compulsions, paranoia, hostility, and in some cases schizophrenia (Gau et al., 2011). Parents of children with ASD also appeared to experienced higher levels of fatigue when compared to other parents (Smith et al., 2010).

Due to the higher levels of increased stress and conflict, parents of children with ASD experience higher divorce rates when compared to families with typically developing children (Freedman, Kalb, Zabolysky, & Stuart, 2012). Even for parents who remain married, parenting a child with ASD negatively affected marital satisfaction (Gau et al., 2011). According to Hartley, Barker, Seltzer, Greenberg, and Floyd (2011), marital satisfaction significantly impacted the parental experiences of parenting a child with ASD, particularly for fathers who were more severely affected by their child’s symptomatology.

In a study completed on the impact of marriage for Taiwanese families who have a child with a disability, it was found that the majority of participants’ marriages were strengthened (Huang, Ososkie, & Hsu, 2011). The mothers in this study shared that their husbands accepted their child with a disability either right away or with the development
of the child. They also shared that their husbands became more considerate and showed more concern for their child. They also reported that the stress of parenting a child with a disability added more strength becoming a catalyst to improve their marriages. In the same study by Huang, Ososkie, and Hsu (2011), 20% of the participants reported that their marriages ended in divorce due to their husbands holding more traditional values and believing that a child with a disability brought shame to the family.

Although the adjustment to having a child with autism spectrum disorder may be difficult from a parental perspective, there are different avenues of coping within the adjustment phase. As mentioned above, there are various issues that may arise from having a child with autism spectrum disorder. As a parent, there is a choice between feeling hopeless and feeling empowered in order to cope with these varying difficulties.

**South Korean parents’ experiences with children who have autism spectrum disorder.** There are currently no published studies completed in the area of South Korean immigrant parents’ experiences of having a child with autism spectrum disorder but a study has been completed with non-immigrant mothers who reside in South Korea. You and McGraw (2011) interviewed 14 mothers residing in South Korea to share about their experiences of having a child diagnosed with ASD. It was found that most mothers who have a child with a disability in Korea socialize and educate their child intensely in order to conform to the ideals that are expected from children. Academic achievements were emphasized, not only for the child with the disability but for other children as well.

The women in this study had difficulties with the idea of shame as family members and even strangers were blaming them for having a child with ASD. These
women found comfort with other women who were in similar situations and began to define a new meaning for what normal was for them (You & McGraw, 2011). Like most Korean mothers, the mothers with children diagnosed with ASD believed that their children’s success was tied to their own success.

According to You and McGraw (2011), the women talked about getting looks from strangers, especially in a behaviorally challenging situation. Some of the women believed others feared what ASD was and did not want to be near their child. Some of the women struggled with sharing that there was something wrong with their child while others struggled with being blamed for the child’s ASD, especially if the child was the first-born son. Despite South Korean’s views of children with disabilities, the women showed resiliency in their efforts to normalize having a child with a disability. They chose to focus on being good mothers and raising successful children.

In another study by Grinker and Cho (2013), a group of parents in South Korea were interviewed regarding the concept of “border children.” This term was defined as children who display ASD tendencies but parents did not want the formal diagnosis. The parents interviewed shared that their border children did not have ASD because they attended regular schools and they appeared to be meeting their intellectual goals academically. Another reason why the title border children was preferred over ASD was that the parents feared that the ASD diagnosis would have a negative impact not only in school but that other parents may stop their children from socializing with the child diagnosed with ASD.
Due to there being no current published studies completed in the area of South Korean immigrant parents’ experiences of having a child with autism spectrum disorder, this present study will attempt to focus on the discovery and understanding of the mentioned population’s experiences.

**Summary**

The content of chapter one reviewed the existing literature surrounding and related to the current research study. It outlined the four major sections of literature that were reviewed which included acculturation, South Koreans, autism spectrum disorder, and families with children who have autism spectrum disorder. The content of chapter one also outlined the purpose of the study and provided a background for the current research study. In order to address the gap in the literature on South Korean immigrant parents and ASD, the current study focused on the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. Through the use of the phenomenological approach, the current study added to the existing breadth of literature and the areas that aren’t sufficiently yet studied. The purpose of Chapter 1 was to review the literature and present the rationale for examining the experiences of South Korean immigrant parents who have a child with autism spectrum disorder.

The content of chapter two will give an overview of the specific processes involved in executing this study. Chapter 2 describes the methodology, participants, and procedure used in the study. It also describes how the data were analyzed.
CHAPTER II

METHODOLOGY

This chapter details the methodology and design of this study. The main research question for this study was: What are the experiences of South Korean immigrant parents who have a child with autism spectrum disorder? The chapter is divided into the following sections: qualitative methodology, phenomenological research method, description and assumptions of researcher, participants, demographic questionnaire, interviews, procedures, data analysis, delimitations, and summary.

Qualitative Methodology

The key to qualitative research lies within the meaning that individuals socially construct as a reaction to their own world (Merriam, 1998). Since these established meanings tend to fluctuate and change over time, it is important to note interpretations at a particular time and within a certain framework. Qualitative methods typically produce a wealth of detailed information regarding a relatively small sample. Due to the small sample size, however, the results are not generalizable. The use of qualitative methods increases the depth of understanding of the human experience.

In order to understand the meaning and interpretations of the experiences reported by the participants, a qualitative methodology was used. Qualitative inquiry was designed to discover, recognize, and depict the experiences of the participants in their own words (Lincoln & Guba, 1985). In qualitative research, interpretations are formed to allow the researcher to comprehend the meanings people construct regarding their experiences and their world (Merriam, 1998). As Denzin and Lincoln (2005) discussed,
qualitative inquiry allows researchers the opportunity to study constructs within their natural settings, making attempts to interpret phenomena in terms of the meaning people place on them. In the current study, the researcher solicited and analyzed the experiences of South Korean immigrant parents who have a child with autism spectrum disorder, which lends itself to a qualitative method of research.

Before a study can qualify as qualitative research, the researcher must consider several factors (Creswell, 1998). The first factor involves the research question and its wording. The research question needs to begin with either “how” or “what” to make it an open-ended question with a variety of answers that extend beyond “yes” or “no.” The second qualifying factor involves addressing the paucity in the literature regarding the topic. Creswell (1998) stated that there can be no existing theories to explain the participants’ behaviors, and the variables cannot be easily identified. A third characteristic is the need to provide a detailed view of the research topic. The qualitative method produces an abundance of detailed information about a smaller group or cases being studied.

**Phenomenological Research Method**

In order to focus on the participants’ subjective experiences, the researcher determined that the qualitative research method of phenomenology was the most appropriate for this study. The phenomenological approach focuses on how individuals make sense of experiences. The focus is to understand the essence of the experiences regarding a certain phenomenon (Creswell, 1998). In order to thoroughly capture the
phenomenon and shared experience, the researcher interviewed the participants who have directly experienced the phenomena, utilizing open-ended questions (Patton, 2002).

Phenomenological research generally addresses questions that are common in everyday human experiences which are believed to be important phenomena in the field of social sciences. Phenomenological research may also address experiences that may be typical of a group of individuals (Merriam, 1998). It also involves understanding the participants’ experiences through seeing and hearing rather than analyzing statistical data (Creswell, 1998). The current study of the experiences of South Korean immigrant parents who have a child with autism spectrum disorder fits with the phenomenological approach as it focuses on the phenomena and each parent’s individual experiences.

Description and Assumptions of Researcher

A large part of qualitative research is for the researcher to remain unbiased. A phenomenological approach also focuses on the researchers’ attempt to put aside assumptions in order to understand the experiences from the participants’ perspectives. Since 1999, this researcher has had an extensive personal interest in autism spectrum disorder and how it affects individuals. While student teaching and volunteering with the ASD population, the researcher was fascinated to see how each case of ASD was different from the last and how there was an immeasurable amount to learn from studying ASD.

The researcher also worked with an adopted Korean girl with ASD from 2000 to 2002. The experience of working with her was not only educational but was also uplifting. The researcher began to truly understand what ASD was and how it affected
the immediate family, especially the parents. The adoptive parents, who were Caucasian, of this child were adjusting to the world of adoption and special needs. They flew across the world to adopt this child, who was the fourth child of two mentally challenged birth parents who could not care for her. The adoptive parents were unaware their daughter had a disability until she became older. They were devoted enough to provide total care and supply her with the services necessary to treat her diagnosis.

The researcher also has a cousin who is diagnosed with ASD. Through his struggles and triumphs, the researcher’s passion grew for both the autism and South Korean communities. The researcher watched his parents maneuver through the special needs culture while delicately balancing bi-culturalism. This motivated the researcher to further explore the South Korean community and how they are affected differently by autism and special needs. He has become an inspiration to many and also to the researcher.

From these experiences, the researcher decided to dedicate a portion of her future to working with and studying the field of autism spectrum disorder and its effects. The researcher’s assumptions include the following:

1. Individuals of South Korean descent view mental health professionals as an unnecessary route for treatment and would rather seek out holistic doctors and/or their families for support and treatment.
2. Having a child with autism spectrum disorder results in more stressful experiences of parenthood as compared to parents who have children developing within the typical range.
3. Having a child with autism spectrum disorder is a stressful and life altering event for the majority of parents regardless of ethnicity, sexual orientation, immigration or marital status.

4. Having a child with autism spectrum disorder may create an isolated environment for the parents, as special needs may be viewed as shameful by the Korean elders.

5. South Korean immigrant parents who have children with autism spectrum disorder may experience higher degrees of depression, anxiety, alienation, and helplessness than Caucasian parents who have children with ASD.

6. Parents who have a child with special needs may experience more marital discord, possibly leading to divorce, as compared to those parents who have children developing within the typical range.

7. South Korean immigrant women who have a child with autism spectrum disorder may fall victim to more types of abuse from their partner due to the Korean patriarchal society leaving women with fewer choices and opinions.

8. Parents who have a child with autism spectrum disorder may become more abusive toward their special needs child due to frustration, resentment, and indignation as compared to parents of typically developing children.

Participants

The participants for this study were South Korean immigrant parents who had a child diagnosed with autism spectrum disorder. In order to meet the criteria for this study, a screening checklist (Appendix A) of the following criteria was created and utilized in order to locate qualifying participants.
The requirements of the participants were that they had to have immigrated to the United States on or before the age of 18 and believe they have retained their culture through the celebrations of traditional holidays and/or language. The participants also needed to have a child diagnosed by a licensed professional with one of the following disorders: Autism Spectrum Disorder, Social Communication Disorder, or anywhere along the spectrum.

**Demographic Questionnaire**

All participants in this study were provided a demographic questionnaire to complete (Appendix B). They were asked their age, gender, marital status, highest level of education, occupational status, current place of residence, religious/spiritual affiliation, number of children, who lives in their household/age/relation/role, age when immigrated to United States, age when child was diagnosed with ASD, number of years child has been in therapy, age of child when treatment began, what type of treatments were utilized, and if the parent had ever been in mental health therapy for themselves. Each participant was listed by his or her assigned pseudonym. In order to protect the participants’ identities, pseudonyms were provided by the researcher. No identifying information of any of the participants such as place of employment, where the child attends school, or location of residence was used.

**Interviews**

According to Merriam (1998), in conducting qualitative research, the researcher functions as the primary instrument in the study. In the current study, the researcher was the main source of gathering and analyzing the data as well as expanding understanding.
through the interviews conducted. In order to determine the experiences of the participants, semi-structured, open-ended questions were used (Appendix C). These semi-structured interviews afforded the participants the opportunity to communicate their experiences about their adjustment to having a child with ASD and other related topics. All of the interviews were conducted in person or on the phone, audio-recorded with each participant’s permission (Appendix D), and then transcribed for data analysis.

The interview questions were developed from the literature and the researcher’s personal experiences. Hand written notes were kept throughout the interview process to capture non-verbals and other behaviors that cannot be captured through audio recording.

Questions for the first interview were:

1. Describe the types of cultural and life adjustments that needed to be made after immigrating to the United States.
2. During your adjustment to your child with autism, what types of coping mechanisms were utilized to overcome the difficulties, stereotypes, and stigmas?
3. How would you describe your experiences as a mother/father having a child with autism?
4. How did being of South Korean descent influence or impact your perceptions of diagnosis and treatment?
5. What do you wish you already knew about adjusting to having a child with autism spectrum disorder?
**Procedures**

Prior to beginning the study, the researcher consulted and received approval from the Kent State University Institutional Review Board (IRB). After the IRB approval was given, the researcher found a ministry for children with special needs and contacted the director of the program. After the initial phone call to the director was made, a participant letter (Appendix E) explaining the dissertation in further detail was mailed to the director along with the screening checklist in order to help in identifying participants. The researcher also created a flyer (Appendix F) with the researcher’s contact information, which the director was asked to hand out to potential participants who met the screening criteria.

When the interested participants contacted the researcher, the details of the dissertation were further explained and any questions were answered during a phone conversation. After the overview of the study was given and the individuals agreed to participate, the researcher completed the screening checklist again to ensure that the participants met the criteria. Once the criteria were met, the researcher arranged a date, time, and place to conduct the first personal interview. In order to accommodate their needs, the participants were given the choice of the location of the interview.

During the initial contact, the researcher informed the participants that this was a dissertation that was being conducted in partial fulfillment of a doctoral degree. They were informed that their participation was voluntary and that they could choose to not answer certain questions or withdraw from the study at any time without penalty. They were also informed that a packet of paperwork including a consent form for participation
(Appendix G), a demographic questionnaire (Appendix B), an audio consent form from the IRB (Appendix D), and a research participant receipt (Appendix H) would be mailed to them for completion. The participants were also encouraged to contact the researcher at any time if there were any questions or problems that arose. Three days before the scheduled interview, the researcher called to confirm the interview and its location.

On the day of the first interview, the researcher collected the packet of information containing the consent form for participation (Appendix G), audio consent form (Appendix D), the demographic questionnaire (Appendix B), and research participant receipt of compensation (Appendix H). If the forms were not completed, the participants were handed blank ones to complete prior to the interviews. The researcher collected a signed copy of the consent form, audio consent form, and research participant receipt and gave a copy of each form to the participants for their records. The researcher also collected the demographic questionnaire.

The researcher reminded the participants that this was a dissertation that was being conducted in partial fulfillment of a doctoral degree. It was reiterated that their participation was voluntary and that they could choose to not answer certain questions or withdraw from the study at any time without penalty.

During the interviews, the researcher used a digital audio recorder and took notes of participants’ nonverbal behaviors, gestures, and cues. In order to note any differences or changes in the participants’ responses and to gain thorough and detailed information, two interviews were conducted for each participant over the course of four to five months.
**Interview One**

The researcher allotted 90 minutes for the first interview. During this time, the participants were asked open-ended questions and unscripted follow-up questions related to their experiences to having a child with autism spectrum disorder. The questions asked were:

1. Describe the types of cultural and life adjustments that needed to be made after immigrating to the United States.

2. During your adjustment to your child with autism, what types of coping mechanisms were utilized to overcome the difficulties, stereotypes, and stigmas?

3. How would you describe your experiences as a mother/father having a child with autism?

4. How did being of South Korean descent influence or impact your perceptions of diagnosis and treatment?

5. What do you wish you already knew about adjusting to having a child with autism spectrum disorder?

After the initial interviews were completed, they were transcribed verbatim by the researcher. In order to ensure anonymity, each participant was assigned a pseudonym and number for use within the results section. Each of the children identified by the individual participants were assigned a pseudonym as well. The second interview was scheduled after the transcript summaries from the first interview were reviewed by the researcher and the participant through member checking.
Interview Two

The second interview was executed in the same manner as the first interview. However, the researcher allotted 60 minutes for this interview. The second interview consisted of follow-up questions. The follow-up questions were asked in order to further clarify answers provided within the first interview and to gain more depth of the answers given if necessary. It also checked for accuracy of the findings and explored any new thoughts that may have occurred to them between the first and second interview. After the second interview was completed, all of the interviews were transcribed verbatim by the researcher. The same pseudonym assigned during the first interview was used to ensure continuity.

Member Checking

Once the completed interviews were transcribed in their entirety, the researcher attempted to establish further credibility through member checking. The use of member checking consisted of the participants receiving a copy of the interview transcript summaries and verifying the accuracy of the interview transcripts. The participants were emailed password-protected transcripts of their interviews and asked to review them, as well as the researcher’s interpretations of the interviews. Any corrections made to the initial transcriptions were disclosed, and the necessary changes were made. After this process was completed with the initial interviews, the same was repeated for the follow-up interviews until each respective participant had reviewed all transcripts.
**Triangulation**

According to Lincoln and Guba (1985), triangulation is used in qualitative research to create credibility. Triangulation is used by qualitative researchers to establish validity in their study by presenting and analyzing a research question from multiple perspectives (Patton, 2002). Although there are various types of triangulation, investigator triangulation was used for this study. The use of investigator triangulation requires that more than one researcher be involved in the study (Denzin, 1970). If the data found in the study can be confirmed and matched by the other investigator without previous discussion, the credibility and validity of the study are strengthened (Denzin, 1970). In order to use investigator triangulation, a graduate from the Counseling and Human Development Services program at Kent State University, was given a copy of the transcriptions in order to review the data and to make comments on the themes that emerged.

**Data Analysis**

NVivo 10, a computer software designed to analyze non-numerical data, was used in the current study. Text-based qualitative data presents various challenges when searching for subtle connections and cross-references, and the numerous features of NVivo 10 were used. Using the features of the software, the gathered evidence – notes, interviews, scholarly references, etc. – was sorted into meaningful categories and themes, allowing the researcher to more fully see patterns as well as discrepancies.

Within NVivo 10, containers called nodes were created to categorize ideas. Nodes can be applied to any single piece of data, thus creating a searchable attribute
attached to interview transcriptions, audio clips, and research notes. For example, the software allowed the researcher to find all sources that fell under the “ASD” node, or to create a report of how often the node “adjustment” appeared. The researcher was able to gather all responses related to an individual participant, or responses of all participants related to a specific topic.

The researcher wrote full transcriptions of the completed interviews, then used NVivo 10 to link them to the audio files. The software allowed the researcher to click on selections of the transcription text, which would then link to the corresponding audio recording. To simplify the analysis, NVivo 10 also allowed for annotations of the researcher’s thoughts and notes, written memos of observations, and a glue feature to combine similar themes. Similarly, the memo links feature allowed the researcher to connect items containing important related observations or insights. Contact summary sheets were created, summarizing information on frequently used words, non-verbal cues, attitudes, and reflective feelings. All these features allowed for the sort of in-depth cross-analysis that would be extremely cumbersome by hand.

**Delimitations**

When approaching this research, there were a few delimitations that were imposed by the researcher. The first delimitation was to choose the research question of what the experiences of South Korean immigrant parents who have a child with autism spectrum disorder were. The researcher could have focused on other areas of South Korean immigrants or parents who have children with autism spectrum disorder, but
decided that putting those two factors together would disclose more specific information for the population that has never been researched before.

Due to the research being a phenomenological qualitative study, the researcher chose to keep the participants minimal. The nature of the interview process took considerable time from the participants’ perspective as well as the researcher’s. Due to this aspect, there were only six participants in this study.

The participants were also only found in the state of California in areas that were considered to be diverse. This was simply due to the reason that the researcher was based in California. If the search for participants were open to all areas of the United States especially in more homogenous or rural areas, the participants may have had a completely different experience.

Due to personal interest of the researcher, the study was also limited to South Korean immigrants and not to all immigrants. The researcher chose to limit it to this population due to the differing cultural variations, views, and opinions of the special needs population. If the study were open to all immigrants from any country, the researcher would not be able to draw conclusions of the data gathered.

Given these delimitations, the results of the research study may be applicable to:

a) South Korean immigrant parents who immigrated to the United States on or before the age of 18, b) South Korean immigrant parents who have a child diagnosed with ASD, and c) South Korean immigrant parents who continue to have a relationship with some extended family.
Summary

Chapter two focused on the methodology and design of this study. Due to the lack of research completed on South Korean immigrants and how they experience their child with autism spectrum disorder, a qualitative approach was utilized. In order to thoroughly capture the phenomenon and shared experiences of the participants, a phenomenological methodology was chosen. By using the phenomenological approach, the researcher was able to focus on the participants’ subjective experiences and how individuals make sense of their experiences.

The purpose of the current study was explained within chapter two. The detailed procedures along with the criteria for participants chosen were outlined and described in this chapter. The researcher’s assumptions were also explored, and the process of the data analysis was reviewed.
CHAPTER III

RESULTS

The third chapter presents the results of the phenomenological study that focused on the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. This chapter has three sections. The first section of the chapter focused on participant demographic information and a summary of their experiences as a parent who has a child with ASD. The second section focused on the summary of the results gathered from all completed interviews including the themes that emerged from the data. The third section summarized the chapter in its entirety.

Participants

There were six participants whose ages range from 36 to 48. Each participant completed a screening checklist (Appendix A) and met the criteria required to participate in the study. Therefore each participant was an immigrant from South Korea having immigrated on or before the age of 18 and had a child diagnosed with Asperger’s Disorder, Autistic Disorder, or Pervasive Developmental Disorder Not Otherwise Specified. The participants also believed to have retained their culture through the use of the Korean language and celebrations of traditional holidays.

Each participant was provided with a demographic questionnaire (Appendix B) to complete before the start of the research. The demographic questionnaire revealed that the ages of the participants ranged from 36 to 48 and all the participants were female except for one. All of the participants were married and all but one had completed 4 years of college. All of the participants immigrated before the age of 18 and all of the children
were diagnosed with autism spectrum disorder prior to the age of 6. Table 1 references the demographics of the participants below.

Table 1

Demographics of Participants

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<tr>
<th></th>
<th>Yoosun</th>
<th>Myung</th>
<th>Eunsook</th>
<th>Haeshin</th>
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<th>Soojin</th>
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<td>2</td>
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<td>3</td>
</tr>
<tr>
<td><strong>Age when Treatment Began</strong></td>
<td>2.5</td>
<td>2.5</td>
<td>4</td>
<td>8 months</td>
<td>4</td>
<td>13 months</td>
</tr>
<tr>
<td><strong>Time since diagnosis</strong></td>
<td>8.5 years</td>
<td>8.5 years</td>
<td>16 years</td>
<td>10 years</td>
<td>7 years</td>
<td>8 years</td>
</tr>
<tr>
<td><strong>Participation in Mental Health Therapy for Self</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>One year</td>
<td>None</td>
</tr>
</tbody>
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Table Notes: SAHM = Stay at home mom
Yoosun

Yoosun is a 42 year old South Korean woman who immigrated to the United States at age three. Yoosun appeared to be a highly self-aware individual having done extensive reflective work on herself and her process with the autism spectrum disorder diagnosis through prayer, writing, and leading special education ministries for other affected parents and families. This was apparent by her insightful responses to the interview questions. Yoosun was willing and ready to share her experience and had much information to share.

At the time of the interview, Yoosun was self-employed and married. She had completed four years of college and had a bachelor’s degree. Yoosun had never been in mental health therapy for herself. She reported that her son had participated in speech therapy for nine years, Applied Behavior Analysis (ABA) for nine years, special education for ten years, occupational therapy for five years, and Relationship Development Intervention (RDI) for two years. Yoosun lived in the home with her husband, their son diagnosed with ASD, John, and a typically developing child, Michael.

Having immigrated at such a young age, Yoosun relied on her parents to recently remind her of what her struggles were. She stated that she began recollecting differences when she was in elementary school around third or fourth grade. Yoosun shared, “I had to coach my parents not to bring Korean food out, and I had to coach my dad not to come out in a nan-ning-goo, that he had to wear a robe like other American dads did” and was very aware of her differences and did not want to stand out because of those differences. She identified more with the American culture than she did with the Korean culture, an
identification which gave her strength to later fight for her son’s rights to services throughout his schooling years.

Yoosun said that language was an obvious hurdle to immigration but getting accustomed to the daily nuances of the cultural differences - such as what to pack for lunch and telling your friends to remove their shoes when entering the house - were also difficult. Yoosun shared, “Apparently I learned English from Sesame Street.” She also noticed obvious cultural differences when it came to lifestyle such as, “My friends would come over and they would be surprised that I needed to tell them to take off their shoes.”

Yoosun’s son, John, was first diagnosed with ASD at age two and a half and treatment began at age two and a half. She was at first convinced that John had language confusion due to their world travels and living abroad. John was exposed to roughly five different languages, and Yoosun suspected that he was not speaking due to not knowing which language to learn. Although she was taking a credential course in education and had chosen autism spectrum disorder as her topic of study, she was not prepared for the diagnosis. Yoosun explained that her recollections of that day are as vivid as others describing remembering the day that JFK was shot sharing, “Nothing can really prepare you for when that diagnosis comes.” She shared that it was the most devastating day and experience of her life. The loneliness of being the only special needs family, that she knew of, within her overachieving Asian American community, set into motion five years of what she called, “functional depression.” Treatment for her son John had already begun but she was still very depressed about the initial diagnosis. Yoosun stated that a death of a child and a diagnosis of a disability were the most devastating things a parent
could experience. Perhaps the death of a child was worse, but that there was at least a finality to death; to having a child with a disability, she stated came with a lasting combination of both grief and hope.

After the initial diagnosis, Yoosun stated she coped by allowing herself to be very angry and to truly grieve the loss of her idealized child sharing, “I would say the best thing I did, and I’m glad I did, is that I gave myself permission to really grieve and get really angry.” Although she had eight months to prepare for the diagnosis through the testing period, it still was not enough to adequately prepare her for the moment when the diagnosis was received. She sought help by reaching out to trusted friends and family during the testing phase so that she had some support when the diagnosis was received.

Yoosun talked about the outpouring of support that she received from her community, even if people did not understand what she and her family were experiencing. She even attributed her own growth to John’s diagnosis, stating that it made her a better parent and a better Christian. She said that she had a true faith crisis with God and did not understand how a devout Christian doing mission work would have to go through this hardship. She always trusted the advice when people told her that it may be difficult now but that it does get better. Having a typically developing child to compare John to carried with it positives and negatives, and Yoosun experienced heartbreak in seeing Michael function with ease on tasks that John would struggle with sharing, “Every milestone is always a stab to the heart of a reminder of what John is not gonna have.” She, however, stated “I appreciate you know, developmental milestones that other typical parents take for granted because we had to work so hard for them with
Yoosun expressed that parents who have both a typical child and a child with ASD, as herself, should appreciate each child for what they individually offer, rather than comparing the two.

Yoosun described her experience as a parent to a child diagnosed with autism spectrum disorder as stressful. “It’s extraordinary stress compared to if I just had typical children.” She explained having to juggle therapies, work, finances, and schools in order to ensure that John was getting all of the services and therapies that he needed and for which he was eligible. “Shocking and breathtakingly simple” is how Yoosun expressed her parenting of a typical child. She stated that she does sometimes regret comparing her two children, but is grateful to have the comparison in order to “enjoy the things that a typical parent would take for granted.” She reflected, “There are surprise blessings.”

When asked how being South Korean influenced her perceptions of diagnosis and treatment, Yoosun recalled the difficulty of telling her parents. “My mother freaked out,” she exclaimed. “Don’t even use that word about my grandson.” She also shared that there was not only shame and guilt thinking she did something during the pregnancy to harm her child, but there was disappointment in knowing that her son would never fit into the “Korean mold” of going to a four year university and becoming a doctor, lawyer, or engineer. Her mother’s shock dissipated, and she eventually supported Yoosun, but shame and embarrassment persisted from her in-laws. They did not tell their friends or family and wanted to “keep it quiet.” Yoosun stated that she was glad to be more “American than Korean” when it came to accepting and treating her son.
When asked what she would have liked to have known about the adjustment to having a child with ASD, Yoosun mentioned that, in hindsight, that there’s no need to “freak out about that early intervention window.” She explained that what she knew about early intervention made it appear to be a “now or never” view on teaching John and became “obsessive and you just eat, live, and breathe it,” she explained. Yoosun expressed that realizing ASD was going to be a permanent part of her life was a moment of clarity to not become so obsessed about early intervention.

If given the chance to do it all over again, Yoosun asserted that she would not feel so much pressure from outside obligations, like church. “I wish I hadn’t been kind of imprisoned or conflicted by people’s expectations, social expectations, cultural expectations, leadership expectations.” She wished that she had focused more on what John needed at that point in time: his treatments and therapies. Yoosun described that change happened for her and her husband when they were not completing homework assignments given by John’s therapist due to obligations at church. She shared that she felt caught between two cultures, but now more clearly understands the internal conflict she felt during that time.

**Myung**

Myung is a 43 year old South Korean man who immigrated to the United States at age four. Myung was energetic and open to sharing about his experiences regarding his son diagnosed with autism spectrum disorder. He answered all of the questions asked and provided further information related to the questions. Myung appeared to be very
comfortable with himself and his experiences demonstrating that he has had adequate
time to process his son’s diagnosis.

At the time of the interview, Myung was employed full time and married. Myung
had completed four years of college earned a bachelor’s degree, and has never been in
mental health therapy for himself. He reported that his son had participated in speech
therapy for seven years, Applied Behavior Analysis (ABA) for seven years, occupational
therapy for nine years, special education for eight years, and Relationship Development
Intervention (RDI) for four years. Myung lived in the home with his wife, their son
diagnosed with ASD, Mark, and a typically developing child, Samuel.

Myung shared that his parents raised the children as Americans stating, “I mean,
we are Korean, but, you know we’re, he [his father] wanted us to have our identities more
as Americans than Koreans,” and although they started out practicing some Korean
traditions, they ended up doing away with them as their predominantly non-Korean
community did not encourage such traditions. He went on to explain that his parents
were concerned that he would not understand English once he started school and
therefore no longer spoke Korean in the home. Myung explained that his parents later
regretted this decision and did what they could to bring back the traditions and the
language. He reported that he identified more with the American culture personally and
it was not until he entered college that he started being exposed to more Korean and other
Asian cultures. He recalled wanting to re-learn his own culture and subconsciously
seeking out a Korean woman to marry and with whom to have children. When he
eventually married a Korean woman, his parents were thrilled.
Myung expressed that the biggest cultural adjustment that needed to be made was identifying as Korean, then as an American, and attempting to re-identify as a Korean-American. He shared that once he turned 18, he realized what he had been missing stating, “We regretted about the fact, here we had all of these Korean friends who were bilingual, you know, and they practiced all these Korean cultural things, and we’re, like, what have we been doing for the past 18 years?” After this realization, he shared that he attempted to “recapture our identity.”

Myung stated that Mark was first diagnosed with autism spectrum disorder at age two and a half, and treatment began at that time. He reported that he had no idea what ASD was and experienced a brief stage of denial. He shared that he felt he had some time to grieve before moving toward the business of providing therapies for his son but did not feel he had adequate time and explained that he masked his emotions. “I just didn’t know what autism was,” Myung stated. He shared about his grief over losing the son that he imagined he would have and imagined for him. He also shared that daily life perpetuates that grief. He referred to the moment when he realized that his son was going to be unable to independently sustain himself, even with a simple task such as working at McDonald’s. Though the grieving thoughts have decreased in frequency, expressed Myung, the grief was alive and well. He said that he wished other children could be more like Mark, more simple in their thinking and not so dependent on achievement to provide happiness.

After the grief, he moved into anger and blamed God asking, “Why out of all people did this happen to me?” Myung recalled feeling even more angry toward God
because he had already endured a lot of suffering in his childhood, and this was adding insult to injury. Once he felt he had grieved appropriately, he shared, “Enough with the grieving. Let’s roll up our sleeves, and let’s just get down and dirty. It’s time to get to work. Let’s do what it takes to support our child because it’s the most, this is the most important time.” He went into a “fix it” mode with a mission to sacrifice anything that he possibly could for his son during this most important time in his life.

Myung described that his love for his son is so profound that it physically hurts at times. He mentioned that he wants to pour out so much to love Mark, protect him, and teach him, but since he cannot do those things, that also hurts him. Although his wife is more functional in regards to dealing with the diagnosis than himself, he connected more with his son on a deeper level of understanding. He was surprised to find himself connecting with Mark more than his wife because he assumed that his wife would be more nurturing with their son.

Of all the participants, Myung was the only person who spoke of ASD as separate from his son making it a point in sharing about his anger regarding the ASD diagnosis rather than his son himself. He was very aware of what he was saying and corrected himself to speak of ASD as its own entity, and not concurrent with his son. When asked, he stated that he had not really thought about it but that it may have helped him to cope and not misdirect his frustrations to Mark.

Myung’s experience, as a parent, was different from that of his wife. Myung stated that since he was the head of the household he felt “a lot more fear” taking on the protector mentality. “I want to protect him from people who might stare him down.” He
also felt a strong urge and need to control everything in Mark’s progress, as well as a sense of responsibility to teach his son social graces and public etiquette.

In recalling a very emotional moment, Myung shared about the first time that his son went on a school bus. Myung described the event in full detail: He had stayed home so he could walk his son out to the bus stop. He fastened him into his five-point harness on the bus, then stepped off, barely able to see his son’s lost eyes through the window. Myung helplessly watched the bus leave and turn the corner, out of view. He then walked back into the house with his wife, sat on the couch, and broke down into tears. He did not realize it then, but in hindsight he said it was difficult for him because that was the first time that he had to relinquish his son to someone else’s care. It was the complete release of control that was hard for him.

When asked if his being of South Korean descent influenced his perspective or decisions of diagnosis and treatment, Myung stated that it did not stop him from seeking treatment whatsoever. He wanted to make the best decisions on behalf of his son, and get him all of the necessary therapies. It did, however, create some distance in his relationship with his father. Myung explained that his parents initially made suggestions of different types of treatments they should try but as time passed, they became more distant and appeared to have an “avoidant” approach to his family. He expressed he was hurt by the distance and longed for his parents to be more involved.

Myung expressed that, prior to Mark’s diagnosis, if he could have known not to seek complete control, he may have been less angry. He stated that the need for control only hurt himself and his family. Experience also taught him that stress eventually turns
into anger, and that anger “eventually got vented in different ways,” but was not always positive. Myung talked about relationship development intervention (RDI), a behavioral treatment, and how helpful it was to learn it, but he was not convinced that having known these skills would have made the adjustment to being Mark’s father any easier. He stated that it might have been beneficial to know the skills before the diagnosis, but it was quite a leap from knowing the skills to applying them.

When asked what he would do differently if he could do it over again, he said that he would have “swapped roles” with his wife to be a stay-at-home parent. Myung mentioned that he had more tolerance for his kids than his wife, who was more efficient at scheduling, and other business-like relationships. He lamented that it was the need to earn money that prevented him from staying home to enjoy time with his son.

**Eunsook**

Eunsook is a 48 year old South Korean woman who immigrated to the United States at age 17. At the time of the interview, Eunsook was currently employed full time and married. Eunsook had completed four years of college and earned a bachelor’s degree. Eunsook was very willing to help and even stated that she had other mothers in her mother’s group that would meet qualifications. Eunsook was forthcoming with her responses going into great detail about her experience with each question.

Eunsook had never been in mental health therapy for herself but had attended a few sessions with her family. She reported that her daughter had participated in speech therapy for ten years, special education for 13 years, occupational therapy for ten years, and a transition program for three years. Eunsook lived in the home with her husband
and their daughter diagnosed with ASD, Karen. She does have an older typically
developing daughter, Kim, who does not live in the home.

As gathered from the interview, Eunsook’s daughter was first diagnosed with
autism spectrum disorder at age six but treatment began at age four before the diagnosis
of ASD because she was initially diagnosed with a learning disability. She stated that
since her symptoms were mild, the assessment did not initially show that she had autism
spectrum disorder. Eunsook also reported that her daughter was not socially awkward at
the beginning but that it continued to progressively become worse.

Eunsook shared that she moved to California after the diagnosis of her daughter
because a speech therapist had told her that California had more services for special
needs children. She said, once she moved, she began to make connections with other
parents and support groups which provided her more strength to talk about her daughter’s
diagnosis. She admitted that she was not public with the information for about ten years
other than sharing with her immediate family and close friends. As time went on, Karen
became better in public and the more she talked about Karen’s diagnosis, the easier it
became for her to adjust and accept it. She also stated that she did her best to expose her
to “the outside world” so that she would learn and understand how to behave in certain
situations.

During this adjustment process, Eunsook mentioned that it was difficult to share
and gain support from her in-laws as they spoke out of ignorance and said things that
were not helpful and at times even hurtful. She said that her in-laws still believed Karen
would still be able to get married and lead a normal life. Eunsook expressed her
frustration regarding having to explain to her in-laws about autism spectrum disorder and how it was not well received by them. Although her in-laws were not the most supportive, Eunsook mentioned gaining support by sharing her experience with other people and educating them on ASD. She also shared that Karen had a very rare medical condition which caused her to have seizure type episodes. Due to the medical condition exasperating her need for further support, Eunsook explained how her group of friends evolved and believed that there were caring people no matter what the cultural background. She just had to find those people. She also realized that the more she shared about her situation, the more other people responded and was able to locate more services for Karen.

Eunsook shared about finding a network of people she trusted with her daughter that was not family. She shared, “Seeing other parents going through the same thing kinda helped to, to deal with it too.” She stated that she was lucky enough to find a live in nanny who had been with her family for ten years. She credits finding her nanny because she sought help and was not afraid of talking about her personal situation about Karen. Eunsook wanted to remind parents that in order to be surrounded by good and caring people that reciprocation was necessary. She believed parents were too focused on academics for their special needs children when socialization and life skills were by far more important to survival in their adult lives. With this belief, she was happy with the decision of exposing her daughter to many different environments and situations.

Eunsook shared a strong passion for educating the siblings of those children diagnosed with ASD. She shared her own experience and how difficult and traumatic it
was for her typically developing daughter, Kim, to figure out on her own, why her sister was the way she was. Eunsook explained her realization after her family was in therapy, how difficult it must have been for Kim. She wished she would have taken the time, back then, to educate Kim about ASD. She also expressed how supportive Kim was to her sister Karen, even through her own difficulties. Eunsook shared with pride that Kim took Karen to her senior prom explaining that since her sister will probably never have a wedding and get married, she wanted her sister to at least enjoy her high school prom.

Eunsook shared another story about her self-image and how she was in a bible study group where the topic of idols was discussed. She stated that she listened to everyone talk about how they idolized their children, their spouses, and such but when it came to her turn, she expressed that her idol was her image. She felt that she had the perfect image of a good marriage, good education, good house, social status, and her high achieving daughter which all fit into her image. But once she had Karen, she felt it shattered her image and all of those things crumbled. She explained how she still continued to struggle with her image and what it meant but felt that it had drastically changed.

When asked about her adjustment to immigration, Eunsook stated that language and too much freedom to make her own decisions were the most difficult to adjust to. She shared, “My parents didn’t speak a lot of English so we kind of had to take on all the decision making like what to major in college and so forth, ourselves.” This was a difficult change that she had to adjust to because in Korea “we’re kind of told, either told
or geared, like the road was already there.” Eunsook also talked about the language barrier and having to learn to communicate on behalf of her parents.

When asked how she coped with the diagnosis, Eunsook said she never coped with or dealt with the stress. She shared, “I don’t think I ever coped with any stress, I kinda, it was hard because her behaviors were pretty tantrummy and daily routines even taking care of it was hard enough. So I don’t think I ever dealt with it.” She explained that coping began to slightly happen when the family relocated in order to get different services for Karen. Eunsook explained that Karen was originally diagnosed with a learning disability and the ASD was never addressed. “Seeing other parents going through the same thing helped to deal with it.” She also said that “being open makes it a lot easier” when talking about beginning to cope. Eunsook mentioned she had feelings of guilt and shame for about four to five years after the diagnosis often blaming herself for possibly contributing to her daughter’s condition.

Eunsook described her overall experience as Karen’s mother being a positive one. She does admit thinking that “Sometimes, to be honest, I wish I didn’t have a child with autism. My life would’ve been much much better.” She felt resentment toward her daughter who kept her from what she describes as a “perfect life.” In looking back and reflecting, Eunsook expressed her gratitude by saying, “I’m kind of thankful that I’m given a chance to raise someone like her,” stating that her daughter was a mission from God that was planted there to serve a greater purpose.

As a Korean American immigrant, Eunsook stated, “You know it’s different because it’s a lot more depressing to be honest with you, they kinda look down at you
when you have an autistic child or disabled child, I mean our culture is that way.” She stated that there was a “real limited acceptance” and even “my parents didn’t want to accept it.” Even after the partial acceptance by her parents, they continued to question her choices of programs for Karen and chose not to share with others the fact that their granddaughter was diagnosed with ASD. Eunsook explained that although her personal perceptions were not influenced by the fact that she was Korean, it was depressing for her to be around other Korean people who were not accepting of Karen. She said that she hated having to explain why Karen was the way she was to other Koreans but went on to make a ministry out of educating people about ASD and special needs in general.

When asked what she wished she already knew about autism spectrum disorder before having her daughter, Eunsook said that knowing more information would not have helped. She had the chance to take psychology and special education courses while she was in college, “So I wasn’t too shocked.” But she explained that it is “hard because it’s daily and you’re living in it so it’s not an easy job. It’s hard.” Eunsook said that there is a large difference between “knowing something and living something.” Although she had the minimal knowledge that made the initial diagnosis a bit easier, that knowledge did not make the daily life with her daughter any less complicated and stressful.

If Eunsook had the chance to do it all over again, she wished she had reached out quicker to other people to gather support and ask for help, “I would get a lot more people involved.” Although she often felt that she could raise her daughter on her own without community support, looking back, she wished she had reached out and put herself out there quicker. “I’m very grateful that I knew my limits and that sometimes I needed help
and when I reached out there were people that reached back.” Eunsook also expressed that if she had a second chance, she would be a lot more open and honest with Kim about ASD. She regretted focusing too much time on Karen and expected Kim to be self-sufficient at a young age. Eunsook revealed that since Kim had to learn about ASD on the internet, she resented her and her husband for not paying much attention to her.

**Haeshin**

Haeshin is a 39 year old South Korean woman who immigrated to the United States at age six. Haeshin was a positive individual and was eager to share in hopes of helping the researcher. She was very forthcoming with her information and responded to each question thoroughly providing a lot of details. She answered subsequent questions with just as much detail and was accommodating in her scheduling of the interviews. Haeshin appeared to be very comfortable with herself and her experiences, which denotes that she has had an adequate amount of time to adjust to her daughter’s diagnosis.

Haeshin reported that her daughter was first diagnosed with autism spectrum disorder at age two but treatment began at age ten months after receiving an at risk diagnosis due to her developmental delays. She had never participated in individual mental health treatment for herself but had participated in support groups and speaking to a psychologist once a week as a participant in one of the support groups. Haeshin stated that her daughter participated in ABA for eleven years from ages one to 12. She also received physical therapy from eight months to grade three. Her daughter continues to receive occupational therapy which started at eight months and speech therapy which started at age three and a half. At the time of the interview, Haeshin was a stay at home
mother and married. She lived in the home with her husband and her daughter with ASD, Mary. She had completed four years of college and had earned her bachelors degree and teaching credential.

When Haeshin immigrated to the United States at age six, she shared that the language was one of the hardest things to adjust to sharing, “I remember watching a lot of Dukes of Hazard and Love Boat.” She explained that the magnitude at which Christmas was celebrated was also quite a shock as it was not too much of a big deal in South Korea. She stated, “The difference is that my mom had to start working, when we came out here, and that was different because she didn’t work in Korea,” and seeing her father more often as he had more set work hours were both adjustments. With age, she had found herself gravitating more toward the Korean culture and finding the urge to learn more about it with the desire to expose Mary to the culture. Her husband, on the other hand, isn’t too fond of the Korean culture. Although he immigrated to the United States later on in life, he does not seem too interested in learning more about it or retaining it.

When Haeshin first learned of her daughter’s diagnosis, she stated that her positive personality helped her to face the problem and not go into denial. She initially thought her daughter was hard of hearing and when the diagnosis of developmental delay was received, she remained hopeful that with enough treatment, her daughter would be typically developing. But when she displayed behaviors of not making eye contact and other delays, she was referred for further testing which confirmed the diagnosis of autism spectrum disorder. Haeshin shared that although she was grateful that she didn’t regress, as other children with ASD often do, she coped by crying off and on for about a year.
She grieved explaining, “My kid’s gonna be different and what does that look like and um as you know, because you have kids, when you have kids you don’t think about what if my kids you know they lack or you automatically think oh, I wonder what they’re gonna be, you know, they’re gonna conquer the world, then all of a sudden that kinda just you know crumbles and shifts and you know, yeah.” She shared that she had a supportive husband and joining parent groups also helped her to cope with the loss of her idealized child. She explained that she still gets depressed about the things that Mary will never do, such as go to college, get married, or have children.

Haeshin shared that her experience as a parent of a child with autism spectrum disorder was probably different stating, “Um, it’s very different. But it’s still good. I’m still a mom. Um I don’t know. I think, I mean definitely it’s different being a mom with a special needs kid, but in the end I’m still a mom.” She expressed that it was easier to take Mary out to places with typical children when she was younger but since her peer group has advanced on to different activities, it had become harder to socialize with her peer group and their parents. She attempted to raise her daughter as she would a typical child, and although strict, she felt that it was helpful for her to have limits for her behaviors. Haeshin felt that she would be more relaxed if she had a typical child since she needed to be hands on at all times with Mary, but still celebrated each milestone and does not take anything for granted.

When asked if being of South Korean descent influenced her perspectives or decisions of diagnosis and treatment, Haeshin said that it did not stop her from finding the services her daughter needed but she experienced a clear divide in the attitude of her
parents versus her in-laws. She stated that her parents were more accepting and proactive in Mary’s treatments and needs sharing, “I mean, they were really sad. But my parents, like my parents are very open,” while her in-laws were quick to ask if they would be having another child, namely a son to carry on the lineage. To this day, Haeshin explained that her in-laws do not know how to interact with Mary and are more interested in how their own son, her husband, is doing.

In regards to the knowledge Haeshin wished she had prior to receiving her daughter’s diagnosis, she stated that she did not have a point of reference or proper resources to help her educate herself but also shared, “Sometimes not knowing is helpful too.” She also was not connected with anyone else who had a child with ASD so she was lost and wished she had more support and for someone to tell her, “It’s not as bad as you think it might be.” She also mentioned that if she was trained in behavior therapy or had a special education background, the knowledge would be translated and applied to Mary. She also wished she knew more about what ASD was so that she would not have expected a classic textbook child with ASD.

When asked what she would do differently if given the chance, she expressed that she would get Mary into social groups earlier and would take her to more therapeutic settings in order to increase her social skills. Haeshin also stated that she would not have stressed so much in Mary’s first four years of life and may have “gone on more vacations with her when she was little because it was so much easier.”
Jeong

Jeong is a 43 year old South Korean woman who immigrated to the United States at age 18. Jeong was very emotional throughout her interview and appeared as though she had not had the proper time to process completely through her experiences of being a parent to a child with autism spectrum disorder. Listening to her story, Jeong also appeared to have many other stressors that the other participants did not experience. Although she was forthcoming with the information and not shy about sharing her experiences, it appeared that she had not done this a lot which brought about a lot of raw emotions and tears.

Jeong reported that her youngest son was first diagnosed at age four and treatment began at that time. She stated that she participated in mental health therapy for about one year while taking her older son for therapy for his ADHD diagnosis. She also participated in her own individual therapy for about three months during that time. Jeong shared that her son received speech and art therapy from kindergarten to third grade. She also stated that he received behavior therapy from kindergarten to fifth grade due to not being able to socialize with peers and becoming overly emotional at school. He also took ADHD medication for one year but terminated. At the time of the interview, Jeong was married and lived in the home with her husband, her older son, Nathan, older daughter, Emily, younger son diagnosed with ASD, Peter, and her biological parents. Jeong had completed some college and was self employed.

When asked what the most difficult part about immigrating was, Jeong reported that the language was difficult but being told to stop pursuing her goals and to pursue a
trade that would help financially support the family was even more difficult. She explained, “Yeah so after we immigrated, I had to help my parents, as the eldest daughter, I had to get a trade that was going to make money, like a beautician or something. And that pressure to have to make money and help support the family was really hard on me.” She shared that she had to work as a waitress and a kindergarten teacher before eventually opening up a day care center. She resented her younger brother who was not pressured to stop going to school and had a chance to complete his education due to the fact that he was male. She explained that if she had immigrated at a younger age it may have been easier for her in her adult life to adjust and not resent her parents for making her work. Jeong expressed that she regrets not pursuing her goals and staying in school.

When asked how she coped with the diagnosis of her son, Jeong immediately became tearful stating, “I just cried everyday just crying and even thought about wanting to die. I loved, I love my kids a lot, but even to let all that go and wanting to die. It was like that.” She shared that Nathan was already undergoing treatment for ADHD and Emily was undergoing treatment for anxiety. She never suspected that Peter would have ASD but rather thought it was ADHD. Due to this suspicion, Jeong took Peter to be tested. During this time, she shared that she held all of her emotions in, which quickly turned into depression. She shared that she received no support from her husband, her in-laws, or her own parents regarding Peter’s diagnosis. Due to being the sole breadwinner at that point, she did not have the proper time to grieve or cope but instead had to continue working and taking her children to their therapy appointments alone.
Jeong mentioned that if she would have received proper support from even just her husband, her adjustment and coping may have been different. She even admitted to having suicidal thoughts at one point due to the great amount of depression and stress she was experiencing.

Jeong described her experiences as a parent of a child with autism spectrum disorder as having been very overprotective of Peter sharing, “I feel like he can’t do anything on his own, that I have to do everything for him. And he gets in trouble all the time with his father, so I do what I can to protect him from getting in trouble with his father.” Due to having studied early childhood briefly in college, she understood that ASD was not her fault and did not feel any guilt regarding Peter’s diagnosis. She shared that she had grown to be strong because of Peter and felt that his diagnosis had made her a better person. Jeong did state however that she felt a lot of guilt for Emily who suffered the most when Peter was diagnosed with ASD. Due to the amount of attention that needed to be given to Peter and his therapies, Jeong was unable to spend equal time with all three children. Since Nathan was older at the time of Peter’s birth, he appeared to adjust and function well but Jeong believed that this trauma contributed to Emily’s negative attitude and anxiety.

When asked if being of South Korean descent influenced her perceptions of diagnosis and treatment, she explained that she shared with her church group and co-workers regarding Peter’s diagnosis. She also stated that her limited public outings were not due to embarrassment but her inability to control his behaviors in public explaining, “Like when I take him to the market, he would disturb, one time I sat him in
the cart, and he, how did he, I think he fell holding the cart.” Although she did not carry
the cultural stigmas of shame, her mother-in-law blamed her for overreacting and taking a
normal child to receive an ASD diagnosis. Her family treated her son normally as did her
church community but being left out of public events due to Peter’s behavior was hurtful.

Given Jeong’s background in early childhood education, she felt that she knew
enough about ASD but felt that if her feelings were normalized and understood, she may
not have felt so alone. She also wished that someone would have shared with her that
learning about a specific disability and living through that disability were very different
experiences, which may have helped with her expectations. Jeong also expressed that she
wished there were more resources for Korean parents of special needs children to make
more meaningful connections.

If given the chance to do things all over again, Jeong shared, “I don’t think I
would’ve cried as much everywhere I went. I would’ve accepted it better. How I
could’ve, the treatment, what would help him, step by step, I think that would’ve helped.”
She also shared that she would have taken more time to seek out services for Peter at an
earlier age because at that time she “didn’t know where to go for help.” She also felt that
if she had accepted Peter’s diagnosis sooner, then more treatments could have been
utilized but also felt that accepting it meant she was giving up on him. Another thought
she had was that maybe she would not have gotten married so young or would have
chosen to leave her husband in order to provide a safer environment for her children with
less stress. Jeong regretted not seeking more services sooner and explained that her son
may have had a better opportunity to assimilate with his peers and possibly be higher functioning socially.

**Soojin**

Soojin is a 36 year old South Korean woman who immigrated to the United States at age 23 but immigrated to Brazil at age nine. Soojin had a very positive attitude and had a lot of honest insight to share. She was very willing and felt the necessity of this study to provide more help to other Korean immigrants. She was very invested in this research. Soojin also shared some pieces of information for local support groups that the researcher did not know about which was helpful to pass along to the other parents. Soojin appeared to be a well adjusted, strong individual who was very clear on her experience and what was helpful and not helpful.

Soojin reported that her son was first diagnosed with a developmental delay when he was seven months old due to not meeting milestones and other medical issues. Due to this early diagnosis, he began physical therapy at 13 months and attended a therapeutic clinic preschool from age two to three when the autism spectrum disorder diagnosis was given. Soojin said that her son tried art therapy for six months but stopped due to not seeing any changes. He started speech and occupational therapy at age two and was still receiving those services at the time of the interview. He also received ABA from age four to age seven. Soojin explained that he had never taken any medications and that she had never been to mental health therapy for herself other than attending support groups and parent training. At the time of the interview, Soojin was married and lived in the
home with her husband, her typically developing son, Nick, and her son with ASD, Logan. She had completed her bachelors degree in Brazil and was a stay at home mom.

Soojin explained that when she initially immigrated to Brazil and then to the United States, learning multiple languages was difficult. She shared that they currently speak English, Korean, and Portuguese in the home. She also reported that not having her immediate family with her when immigrating to the United States from Brazil was the most difficult sharing, “It was only me and my husband here. That was the hardest part.” Once she gave birth to Logan, she felt lonely explaining, “Right after our first son was born, and then he started having, I see some, something different with him.” She also talked about the language barrier and missing Korea. Soojin said she shed a lot of tears and believed it took her about a year and a half to adjust.

Soojin explained that receiving a diagnosis of autism spectrum disorder was not a huge shock as she was somewhat prepared after having noticed developmental delays in Logan. She admitted that it had taken her husband two to three years to accept Logan’s diagnosis and that she had not even fully accepted it as accepting it felt as if she was giving up on him. She described crying after receiving the initial diagnosis and made the difficult decision to stay at home with Logan and gave up her career to do so. She often resented her son for cutting her career short especially when financial strains were experienced but dually felt rewarded in watching him develop and grow. Soojin felt as though she had to educate her husband about special needs due to his denial and wanting to treat him like a typical child. But her husband showed his support when he agreed
with her to cut ties with his side of the family due to the stress that her mother-in-law was creating.

Soojin reported that she continued to attempt to raise her sons with the same expectations of behaviors and holds them to the same standards as if they were both typically developing. She also shared, “I try to give him as much attention as I can give,” referring to her younger typical son, Nick. She admitted to expecting more from her typical son, Nick, but does not want to give him the pressure. She also does not want Nick to feel guilty about partaking in certain activities that Logan is unable to. Soojin expressed that she does her best to split equal time with each son especially when their school breaks are different. She is adamant about Logan not affecting Nick’s life such as pressuring Nick to take care of Logan when they are both older. She said that she had learned to be more open minded and patient due to having Logan and also admitted to working on feeling less ashamed of him in public.

Culturally speaking, Soojin expressed her anger when her mother-in-law attempted to convince her to divorce her husband after learning of Logan’s diagnosis sharing, “She was against me and my mom because she didn’t want my husband to suffer for the future because of our son or me, because she didn’t, at the time she didn’t like my character.” Her mother-in-law was only concerned about her own son, according to Soojin, and she did not want her own son to suffer due to having a child with a disability. She also explained that her mother-in-law blamed her for Logan’s diagnosis. After the lack of support from her mother-in-law, Soojin felt that Americans were more accepting of special needs individuals than Koreans were. She noted that she received no support
from her extended family but observed American families celebrating disabilities and not feeling embarrassed or ashamed. She said that she wished she could be more connected with the special needs community but felt a separation due to cultural differences. Soojin was not able to find a Korean support group until Logan was five years old and due to this delay, was unable to find resources or validation for her feelings for a long time. She often wonders how her views on disability may have been different if she would have never left Korea. She believes that she may have shared the same shame and embarrassment views regarding disabilities as her extended family members.

When asked about what she would have liked to have known about ASD prior to receiving the diagnosis, Soojin said, “Maybe uh, give me more information of support that I can have,” referring to resources in the community. If she had known about the existence of a Korean support group she would have attended the group earlier finding more comfort through the process. She also mentioned that she wished there were more community resources for her to tap into in order to educate herself explaining, “Maybe I get less stressed. I tried to talk to more people with special needs because when my son was young, I didn’t get any support, I thought I was the only one.” Soojin said that if she would have known what to expect raising a child with ASD, it may have created less stress for herself which in turn may have created less stress for her family and possibly for her mother-in-law. She also stated that if she had initially received the diagnosis of ASD rather than that of a developmental delay, it would have been easier for her to accept instead of having hopes for improvement in her son.
If she was given a chance to do it all over again, Soojin honestly shared, “You know what, maybe I won’t have babies, maybe I will marry my husband, but maybe I won’t have a baby.” She was quick to explain that she does not have regrets about having children but would have found other ways to be happy with her husband even without them. Soojin reported that she would have more free time and would possibly have less stressful visits with her family which in turn may have improved their relationships. Another possibility is that she may have waited to have children until a later age when they were more financially stable and psychologically ready to accept more hardships.

**Themes**

During the two interviews for each participant, questions and follow up questions were asked to gather data related to their experiences of having a child with autism spectrum disorder. All of the participants shared notable stories and interesting points regarding their experiences as South Korean immigrant parents who have a child with autism spectrum disorder. The answers provided by each participant were individually different but also similar on different levels. As a result, five major themes were created from the participants’ answers. The themes created were: a) Familial support during adjustment, b) Religion and spirituality as a way to cope, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness and e) Cultural differences during adjustment.
Familial Support During Adjustment

One of the themes that emerged from reviewing the participant interviews was that of familial support. In the current study, familial support is described as receiving financial or emotional support from immediate and/or extended family, including the in-laws. All of the participants reported either receiving some type of familial support either positive or negative. Some participants spoke about receiving a surprising reaction to their child’s diagnosis resulting in support while others spoke of their families turning away from them and having a negative feeling toward them. Three sub-themes emerged from this theme of familial support a) received a lot of support, b) received limited support, and c) received no support. The following section takes a closer look at each participant’s experiences. Two participants reported receiving a lot of support from their families, four participants did not receive as much support as they would have liked, and one participant stated that she received no support whatsoever.

Received substantial support. The first sub-theme was receiving a lot of support from their families, which both Yoosun and Haeshin reported. Yoosun shared that her mother “freaked out” when she shared the diagnosis with her saying, “Don’t ever use that word about my grandson. Do you even have any idea how severe, how awful that word is?” After her mother was given a chance to process, Yoosun recalled that they both immediately grieved “and she flew up and wanted to help and get involved and learn and you know all these things.”

Yoosun stated that her parents were glad that she was advocating for their grandson and giving him the services that he needed. Although they were glad that she
was getting all the help for her son, there was still some embarrassment and shame surrounding the diagnosis. Yoosun explained that although her in-laws were not too involved or supportive, she believes to have received all of the emotional support that her parents were capable of providing due to their cultural limitations. She felt satisfied with their desire to learn about ASD and to help while dealing with their own cultural issues and views of special needs while keeping an open mind.

Haeshin shared her experience and stated that she attributed her positive attitude to not going into denial after receiving the diagnosis of autism spectrum disorder. She initially believed her daughter to be deaf and underwent testing and assessments while her daughter was already in treatment for her developmental delays through early intervention. She shared that she had hoped to close the developmental gap with therapies and treatment but it solidified her worst fears when the diagnosis of autism spectrum disorder was officially received. During this time of the unknown, she shared how her parents were supportive of her and present with her while her daughter underwent multiple assessments.

Haeshin shared that her parents were supportive and accepting stating:

You know, I don’t know how they became so open but um, yeah. I, I honestly don’t know, but definitely my mom is not the type to be hiding, like, she doesn’t hide things. Yeah, no, ok, having their support was really helpful. Um, definitely, that they acknowledge it, they’re not denying it, they’re just trying to help me, to cope with things, you know, anytime they’re around, they’re always
like, like my first time I went to Europe, my mom came out and she helped my husband watch my daughter, like both my parents did.

Haeshin explained that her parents were savvy to knowing when she needed a break and were very open about their granddaughter’s ASD sharing the diagnosis with their whole church asking for prayers and also warning their friends regarding what to do and not to do when her granddaughter was around depending on her fears and perseverations.

**Received limited support.** The second sub-theme was receiving limited support. Five participants, Yoosun, Myung, Eunsook, Haeshin, and Soojin fell into this category. Although Yoosun and Haeshin reported having received a lot of help from their biological parents, they also shared the disappointment and avoidant behavior displayed by their in-laws, which was also common amongst the participants in this sub-theme.

Yoosun explained that her parents took an interest to their son and was prayerful and wanted to get involved. But when it came to her in-laws, she shared that although they financially helped, they were not emotionally or physically present or available.

But from my husband’s side, I could tell there was a lot more like, they didn’t tell their friends, they didn’t tell their family or church members for a long time, and for several years, a lot of people just didn’t know. And they just kinda wanted to keep it quiet.

Haeshin shared that her in-laws, due to their traditional beliefs, were highly disappointed for her having cut off the blood line and not producing a son to bear her husband’s last name. She reported that both her mother- and sister-in-law would ask...
about having more children to pry into her plans of reproducing more. After learning that some children diagnosed with ASD have an area that they are savants in, her mother-in-law searched eagerly for areas where her daughter would excel in order for her to have something to brag about to her friends and church members. Haeshin expressed that her mother-in-law had a difficult time interacting with her daughter. The reason for the lack of interaction was because she did not know how but was purely more interested in how her husband was doing, her own son. She continued on to say that even though her in-laws do not understand how to interact with herself or her daughter very well, they do however make feeble attempts to come over and physically be present with her family. Haeshin’s positive attitude explained this behavior as support for her husband which in turn benefitted the whole family.

Myung shared that his parents were not present nor did they provide emotional support but only made suggestions as to what treatments needed to be done and were business like regarding their grandson’s diagnosis. He shared that his father was a medical doctor and when asked if more support was received due to this fact, the answer was no. Myung described his parents’ avoidant behavior regarding Mark and his family while his in-laws were more hands on and involved. Myung excused this behavior by saying that his parents were always attempting to equally distribute their time among him and his siblings which, to him, interpreted as avoidance. He also added that his mother appeared to avoid the family as well but it was more so because she was uncertain about how to be around his son, Mark.
It was more hurtful with my mom. Because I do know that my mom, for the longest time would, and she would never really explain to me why, but she would, she would kind of avoid it for a, to a, to a certain degree. I was frustrated because I just couldn’t understand why it seemed like she was avoiding my family.

He also talked about how he did not expect much from his family and although they did receive some financial support, he would have much rather had them love Mark more and supported him in a way such as providing an opportunity to rest. Although sad about receiving limited support, Myung remains positive about his family and is grateful to have received support and physical help from his in-laws.

Eunsook shared that once she relocated to California after receiving the diagnosis out of state, her parents lived nearby and witnessed the amount of work it took getting Karen to her different therapies, appointments, and programs. She explained that her mother felt sorry for her and received some help from her parents in the form of verbal affirmations. She mentioned that her mother expressed that she believed Karen was still able to go to college and get married. Her in-laws, however, never understood what it took on a regular basis to raise and provide for Karen. Due to this lack of understanding, they often made hurtful statements blaming Eunsook for giving special treatment to Karen and not sending her to a regular school stating there was nothing wrong with her.

She said that although her parents felt sorry for her, they had a difficult time accepting the diagnosis of their granddaughter.

Even my parents didn’t wanna accept it and my mother in law didn’t wanna accept it. So it was hard letting them know that she’s gonna be the way she is.
It’s not like, you know, no matter how much I try there’s a certain limit as to how she can explore and she’s gonna live the way that she is. And so, being Korean, there’s a real limited acceptance. Even if they accept, they don’t know how to express their acceptance.

Soojin talked about how having both sets of parents out of the country was tough to receive the support she desired. She explained how difficult and lonely it was for her. She reported that after her son was born, her mother-in-law came to visit and was only successful in providing more stress and not comfort. Soojin shared that her mother-in-law did not have any knowledge of special needs and blamed her for Logan’s diagnosis. She even attempted to convince Soojin to take Logan and leave her husband so that he could have a more comfortable life.

And then, uh, she started to tell me that I should divorce my husband, let him go, because our son is all my responsibilities and she tried to make up my mom’s mind, you know something about like, because uh, they can’t have the same kind of blame on my mom and that hurt my mom a lot too.

Soojin also shared that her mother-in-law had a lot of shame of having a grandson with a disability in her family. She talked a lot about her typical son, Nick, but appeared to hide the fact that her other son, Logan, had ASD. Due to the stress that this had caused Soojin, she provided her husband with an ultimatum asking to cut off ties with his mother or to divorce her. Luckily for Soojin, her husband decided to provide his full support, which also helped in her coping with Logan’s diagnosis.
Received no support. The last sub-theme was having received no support. Jeong was the only participant that reported not receiving any support from either side of the family. Jeong explained how her journey was uniquely painful and that she had a difficult time not only adjusting to the diagnosis of her son, but to cope alone, even without the support from her husband. She did not have any issues sharing Peter’s diagnosis with her family but the response was meek, especially from her mother-in-law.

My mother-in-law. She kept telling me that I took a normal child to get diagnosed that way and kept telling me, that I was overreacting, it was too much, and she told me things like that.

She reported that her mother-in-law blamed her for Peter’s diagnosis and even went as far as to blame her for her husband’s infidelity. Jeong painfully expressed that her relationship with both her husband and mother-in-law were strained and it was only manageable because her mother-in-law resided in Korea, which significantly decreased contact.

When attending a weekly support group at church to help cope with the difficulties of the ASD diagnosis, Jeong reported that her own mother did not approve and appeared worried for her. She explained that her mother told her she was crazy because she thought she had fallen into a cult following with a negative church to attend those meetings.

Overall, it is clear through these responses that familial support, or lack thereof, played an intricate role in the participants’ adjustment to receiving the diagnosis of autism spectrum disorder either positively or negatively. Some participants interpreted
the support from their families as helpful and necessary while other participants believed it was negative and from a place of discomfort.

**Religion and Spirituality as a Way to Cope**

The second theme to emerge amongst all the participants that were interviewed was the role of religion and spirituality. In the current study, religion and spirituality is described as a coping mechanism or a source of comfort. All but one participant stated that some form of religion, prayer, and spirituality was utilized as a coping mechanism and provided them with comfort or hope. The participants who found religion and spirituality to be a factor stated that it was something to place the blame on but also look to for strength and guidance. Sub-themes derived from this were a) finding comfort, peace, and hope, b) blaming and anger, and c) not a factor. The following section takes a closer look at each participant’s experiences. Three participants reported finding comfort with their religion and spirituality, two participants blamed their religion and became angry, and one participant stated it was not a factor as one of their coping skills.

**Finding comfort, peace, and hope.** In the current study, three people reported that they found comfort in their religion during the adjustment and coping phase. Eunsook, Haeshin, and Jeong all agreed that their religious views provided support and hope. Eunsook believed that God planted her daughter into her life because there was a “mission that needed to be done.” She believed there was something that her family could contribute in a positive way so other people who also had the same situation could benefit or find comfort. Eunsook talked about participating in weekly bible study. She also found that joining a church with a designated special ministry helped her to cope.
I openly talk about it. And I think that helps me to really sort my thoughts and feelings sometimes. And what that kind of means in God’s eyes. And other people also see some insights of people like me going through this, so I think it’s a good thing. I’m a lot more honest I think, in my opinion, than most people. And I actually talk about it a lot more.

Haeshin stated that she believed in God’s plan for her daughter and having faith helped her a lot in coping during the adjustment. She found a lot of hope and comfort stating that, “Knowing that no matter who you are, your worth is still the same to God, helps with perspective.” In the beginning, she indicated that being given permission to blame God helped, especially coming from another church where questioning God was unacceptable. She admitted that turning her daughter’s future over to faith provided her with peace and hope.

Yeah, so you know, um, in special ed church, our pastor always talks about how God has a plan for every single person. Regardless of your background, who you are, he has a great plan but often it’s me who limits that. Um, I actually don’t know what God’s plan is and I pray that I don’t limit Him. What God can do to our daughter we’re not sure. So we’re kinda anticipating. Praying and anticipating.

Jeong continued to experience a lot of difficulties in her adjustment but attributed her faith and prayer to saving her life. She affirmed that since she did not have many friends to turn to, she joined prayer meetings with the pastor’s wife who had a counseling background.
I feel like the support I received from the prayer group was helpful. They prayed for my kids. There’s this prayer that you’re listening to God’s thoughts and sending them to me, so they all supported me and told me that God loves me and that God’s with me and that he knows my future and knows my hardships.

Hearing these things were helpful.

Jeong also tearfully expressed that she had fallen into a deep depression and was at one point suicidal and had thoughts of ending her life. She described how she wanted to be free and to let everything go stating:

I was just lost. I cried a lot, I prayed, (crying) what was I going to do. What was I supposed to do with my son.

**Blaming and anger.** The second sub-theme was blaming and being angry with God. Although Yoosun and Myung did eventually find comfort in their religion and spirituality, they initially blamed and were angry with God for bringing this undue burden into their lives.

Yoosun stated that she felt “gypped” by God and was angry with God because “we had just stepped off the mission field and I felt like, this is what we get for serving you? This is not supposed to happen to a former missionary.” She explained that allowing herself to become really angry and “pissed” was greatly helpful in the coping process. Yoosun recalled all the blessings referring to her son with ASD, a new perspective on life, growth as human beings and Christians, amongst other blessings.

And for me it was a huge faith crisis because I’d been a Christian for so many years and I’d been in Christian leadership for so many years, so it was really a
time, it was just really a testing time, well this is all the stuff that I said I believed but what does this really mean. So I think for me uniquely I know now a lot of parents conclude this way but just really hunkering down in my faith and realist, oh, God is good. Even though these kinds of things happen, God is good.

Yoosun however described that due to this blame and anger that she allowed herself to partake in, she stated that it “galvanized and crystalized” her faith finding comfort in knowing that God knows why all of this is happening. She expressed that having gone through the blame and anger, she is now in a more peaceful place and able to advocate for other special needs parents while incorporating faith.

Myung blamed God for his suffering. He had already had a difficult childhood and said, “Okay. Well, why God, do I have to go through more suffering?”

There is a spiritual aspect of what are your relationships with God, just as much as your relationship with your family, with your children, with all these people, with all these other things. But you cannot deal with this until you deal with the depression first.

He shared that he went into a solid depression and at one point got into a screaming match with God in a church. Myung felt that it was his duty as the man of the household to internalize all of his struggles and emotions in order to sacrifice all that he could for the family. He did not find comfort and peace within his religion until he decided to leave his more conservative church and join another church where he was asked to lead a group for parents with special needs children. Myung partially credits this transition to being able to provide leadership and solace to other special needs parents
while providing himself healing through leadership and ministry. He reported that although he still had days of questioning God, he was solidified in believing that God had a plan for his son and their family.

**Not a factor.** All of the participants, except for one, shared that God played a role during their adjustment phase in some capacity. Soojin was the only one that did not mention any religious preferences or higher beings to explain her son’s diagnosis of ASD and did not attribute any of her coping or survival to religion or spirituality. She does, however, state that she cried nightly and on the urging of her friends sought out a monk and even paid for prayers and healing but concluded that acceptance of her son was the best method of coping for her.

Some participants blamed God, became angry with God, while other participants leaned on their religion and spirituality as a place of comfort. In the end, all of the participants who mentioned religion and God as a coping mechanism were able to make sense of having a child with autism spectrum disorder and found meaning and purpose. This resolution and acceptance helped the participants move forward.

**Guilt and Shame over Diagnosis of Autism Spectrum Disorder**

The third theme that emerged from participant responses was regarding the feeling of guilt and shame. In the current study, guilt is described as feeling responsible for their child’s diagnosis, holding back typical siblings, and/or denial in not wanting to accept the diagnosis. Most of the participants reported feelings of guilt as related to their child’s diagnosis and throughout the adjustment process. The sub-themes derived were a) denial, b) guilt and self blame, and c) cultural embarrassment. The following section
demonstrated the participants’ emotional reactions and how guilt and shame played a large role in their adjustment and overall experience of having a child with ASD. Three participants reported feeling guilty over being in denial, three participants reported feeling guilty and blaming themselves, and five participants reported feeling guilty for being embarrassed by their child for cultural reasons.

**Denial.** In the current study, Myung, Jeong, and Soojin found themselves in denial when dealing with their child’s diagnosis of autism spectrum disorder. Myung shared that he had a brief stage of denial, which was filled with confusion since he had no idea what to expect nor did he know what ASD was. He explained that the denial lasted a few months and after going through the angry phase, he came to a place of business seeking out treatment for his son.

Jeong stated that she never denied that her son needed help but had a very hard time accepting that the diagnosis was ASD. She explained that if she were to accept the diagnosis, then it would be real and she would have to deal with it. She mentioned that she would have much rather had it be ADHD like her older son or something that was not so alarming and permanent.

Soojin admitted that even though it has been years since receiving her son’s initial diagnosis, she still has not fully accepted and adjusted. Although she continued to put her heart into rehabilitating Logan and making him a member of the society, she believed that she should accept him for who he was because he may be done learning at this point. She also felt that if she were to fully accept him, then that would mean she was giving
upon Logan. Soojin mentioned that she continues to struggle between wanting to accept him and not wanting him to behave as though he had ASD.

**Guilt and self-blame.** The second sub-theme was guilt and self-blame.

Eunsook, Yoosun, and Soojin fell under the sub-theme of self-blame for something they may have done wrong in order to cause the diagnosis of autism spectrum disorder. Eunsook felt guilty and wondered if something she did during pregnancy affected her daughter and brought upon the diagnosis. She also felt guilty about neglecting her older typically developing daughter, Kim. She stated that if she were to do it all over again, she would be “a lot more open with her” and “include her to really understand what I’m going through.” She reported that she was so focused on Karen that she almost “forgot about the other child.”

Yoosun expressed that she felt shame and guilt, as if she had failed and immediately blamed herself and thought she had done something wrong during her pregnancy. She stated that she felt somewhat guilty spending more time with her typical son because the time was more enjoyable. She indicated that having a typical child is a “heartbreaking reminder” of the things that John cannot do or has a difficult time doing. Yoosun also felt some guilt over Michael’s difficulties socializing with his peers as he does not have an appropriate social model at home. She shared that Michael speaks to other children the way he speaks to his brother with ASD, which entails a lot of commands and directives. Due to this behavior, Michael tends to get along better with younger children who will follow his directives, much like a leader.
Soojin talked about how she felt guilty when her typical son, Nick, was not invited to social events because he had an older brother with ASD. As much as she does not want Nick’s life to be affected by having a special needs brother, it has become more difficult to avoid especially as they were becoming older. Soojin also stated that she sometimes felt shame when her son would walk in public.

Yeah because his ankle is turned, so his upside goes first, he always walks a little bit funny and I see a lot of kids looking, you know. And sometimes I feel shame but (pause) it’s something that I have to deal with it because it’s not going to, I can’t change for anything. And then sometimes I tell him, you have to do nice walking, walk nicely, without thinking. And then I think, oh my goodness I think I feel shame, I should not do that, you know, he’s my son, sometimes I do, yeah.

She reported that she would catch herself correcting him and felt guilty afterwards. When asked why she felt guilty, she responded by saying that with Nick, she could teach him to be different and to change but with Logan, he was the way he was and she needed to be more accepting of that.

**Cultural embarrassment.** The third sub-theme surrounded the idea of being embarrassed due to cultural responses from the community. All the participants except for Jeong admitted to feeling cultural embarrassment meaning they shared experiences of embarrassment by their child diagnosed with autism spectrum disorder and not wanting to take the child out in public or talk about their child’s diagnosis. Yoosun shared that there was a lot of cultural shame to not fit into the “mold” of going to a good college, graduating, becoming a doctor, lawyer, or engineer, marrying, and bearing a son. She
also admitted that she felt her in-laws were ashamed of her son and wanted to “pray it out” of him. Yoosun affirmed that her mother would still attempt to stop her from taking John out in public or to friends’ houses out of fear that he may break something or that her friends may not like him. She also talked about having to quit her commitments to her church in order to “prioritize my child’s needs” and do what was right for John. Yoosun said that the cultural judgment did not affect her coping with the diagnosis but did interfere with her receiving treatment for her son. She shared that since she felt a strong obligation to her church duties and wanted to appear to “have it together” she often rejected what the therapists requested her to do for John until she became more accepting.

Myung expected that since his father was a medical doctor he would be more supportive and helpful. But since Mark was the first-born grandson to carry on the lineage, there was a lot of disappointment when the diagnosis of ASD was received. Myung shared that in order to cope in their own way, they continued to avoid their grandson, as there was a lot of shame surrounding ASD. He was adamant about separating the diagnosis from Mark putting in the qualifier that his parents were not ashamed of their grandson but ashamed of the ASD. Myung talked about feeling guilty and embarrassed over Mark’s behaviors in public such as shouting, singing, or having meltdowns. He stated that his intentions were to teach him how to properly behave because it is a “cruel harsh world” and he wanted to protect him by preparing him. Although his intentions were good, he often felt guilty for feeling embarrassed of his son.
Eunsook shared that the Korean culture had a tendency to look down on people who had children with special needs in general and kept them hidden. She also described her observation of how Korean people do not seek services due to bringing shame to the family but felt hopeful with more church ministries being created surrounding special needs.

It appeared that all participants felt a degree of guilt surrounding raising their child with autism spectrum disorder. Overall, all of the participants had good intentions and meant well for their children with ASD but often had difficulties putting their own self-image aside to not feel embarrassed and to focus on their child.

**Bitterness**

The fourth theme that emerged from the participant interviews was the feeling of bitterness. In the current study, bitterness is described as jealousy and resentment toward parents with typically developing children and resentment toward their child with ASD or spouse. Most of these feelings were rooted in experiences and things that the participants did not or could not have. The sub-themes derived were a) jealousy of parents of typical children, b) resentment of the child with autism spectrum disorder, and c) resentment of their partner. The following section was a closer look at each participant’s experiences. Five participants reported feeling jealous of typical parents, three participants reported feeling resentful of their child with autism spectrum disorder, and two participants reported resenting their partner.

**Jealousy of parents of typical children.** The first sub-theme is being jealous of parents who have typical children. Yoosun, Haeshin, Jeong, Soojin, and Myung
responded to this theme. Yoosun stated that she often thinks about what it would be like if her life was normal. But since a little over a decade had passed and given her time to adjust to being a mother of a child with autism spectrum disorder, she does not think about having a normal child as much as she did when she received the initial diagnosis. She did, however, think about it a lot more often closer to the beginning. She admitted to talking to her typical son, Michael, more due to it being more enjoyable and easier.

Yeah I think about that all the time. And I think you think about it as you’re closer to it, but as you get further out from it, new normal becomes new normal and that is the new normal and it just becomes a passing thought once in awhile. Like something will happen and you go, “Huh, what if our lives were normal or if we didn’t have this,” but it comes less frequently.

Haeshin was proud of the fact that she grew up not comparing herself to other people but finds it difficult watching her child get older and potentially missing out on certain life events of typical children. She also expressed how hard it was to hold in her emotions at her daughter’s sixth grade promotion as it gave her a glimpse of what was to come and her missing out on college and other life events. She also jokingly said to ask her again in five years.

Missing, um, gosh you know, I don’t really, I didn’t grow up comparing myself (laughter) to other people that much. And I think it’s transferred on having my daughter too, which is helpful. Um, no the only thing I feel like she’s missing out on is maybe potential friendships, you know, that social aspect kind of a thing.
Currently, I don’t feel like I am but I mean but I’m projecting it, it’ll probably get difficult like college, weddings, and things like that.

Jeong expressed having felt a lot of guilt regarding the treatment of her typical children and thought about other parents who did not have this issue of having a special needs child taking away attention from their typical children. She indicated that if she was a parent of typically developing children, they may have had a better childhood experience and upbringing. Jeong explained that since the birth of her third child, who was diagnosed with ASD, she had felt that she pulled attention away from her other two children.

If I only had the two (pause) I probably would’ve been better to the two. I would’ve been better to the two, treated them better. Hm, I don’t know, I’ve never thought about it that way (pause). I would’ve been able to focus on the two more. Especially to my daughter who was hurt a lot when I had my third child, my daughter. She felt, I think she was inner healing. She drew a picture of a heart with a bandage on it. When I asked her what it was, she said when her younger brother was born, she was the last baby, and he took that away, and she lost the love that she had.

Soojin had a slightly different perspective on her jealousy of parents of typical children. She shared that she would have continued to pursue her career if her son was typically developing. She did continue to work after Logan was diagnosed, but after he turned three, the day care he was attending was no longer able to control his behaviors and he needed more assistance. In order to dedicate more time to his education,
therapies, and provide him with more attention, she decided to quit her job and stay at home with him.

Yeah, and then when I see some like some woman, career woman, working, you know, so I feel, maybe little bit jealous. But my life is his mom. Yeah, you know (laughter).

When asked what she missed the most about having given up her career she stated that it was the financial gain. Soojin reported that when her family came to visit that she was not able to provide them with everything she wanted to and she even attributed her financial situation as possibly having a negative impact on her relationship with her mother-in-law.

Having my own career, have better financial situation, and of course money is not everything, but money helps a, a lot.

Myung mentioned these feelings of jealousy and often felt that parents of typically developing children took their development for granted. Myung expressed that when he thinks about his son with ASD having to go through typical life experiences such as puberty, he has a mixture of emotions such as sadness and a twinge of jealousy thinking about other parents who may not have to have this experience. Myung stated that it makes his protective fatherly side come out thinking about the unpleasant experiences his son may have since he loves him “fiercely.” But he also entertains the thoughts of not having a special needs child.

**Resentment of the child with autism spectrum disorder.** The second sub-theme was resentment of the child with autism spectrum disorder. This was a difficult
topic to admit but two participants were able to admit that they have felt resentment toward their child with ASD. Although they have grown out of these thoughts and now realize the positive impact their child has had on their lives, Eunsook and Soojin both used to harbor thoughts of resentment.

Eunsook was the most candid in answering about her feelings and openly shared that she wished she did not have a child with ASD. She expressed how her life would have been much better and perfect without her special needs daughter, Karen. She admitted that the self-image she had planned had crumbled which prompted her to rethink about how she was going to rebuild her identity with Karen in it. Eunsook shared about her high achieving “perfect” older typically developing daughter, Kim, and thought Karen would be exactly like the first daughter.

Sometimes, to be honest, I wish I didn't have a child with autism. My life would've been much much better, actually she has a sister, I have a daughter who is 25 and she's always been smart and she's always the top of her class and she's been a pride and joy and when my second came along, I thought oh I'm gonna have another child just like that. But it turned out not to be like that at all so I kinda resented having her. In the back of my mind, if I didn't have her we would've had a perfect family. My husband is good looking, he's a good business person, I work, and we could've had all this perfect family.

Soojin shared that if she were to have a chance to do everything all over again, she would not have children at all. She stated that there were no regrets of having had her children or her life but, given the chance, she may have found other ways to be happy
with her husband, which in turn may have salvaged her relationship with her mother-in-law.

You know what (pause) maybe I won’t have babies, maybe I will marry my husband, but maybe I won’t have a baby. Yeah. No regrets, but I think if you, I weren’t to have a baby, maybe I’ll find out other ways of happiness you know. Of course I’m happy with my kids, they give me a lot of happiness, they teach me a lot of things, but if I wouldn’t have them, maybe I’ll have happiness in other situations. I’d learn other things. I think.

Soojin also indicated that she gave a lot of priority to certain things like money and her career prior to having children. Although she initially said that it was easy to give up her career and had less stress as a result, she did sometimes resent her son for almost forcing her to make this choice. She does however add that when she sees Logan growing up happy and healthy, it makes her feel better about her life and the decisions that she has made for him.

**Resentment of their partner.** The third sub-theme surrounded some of the participants’ resentment of their partners. Jeong and Soojin both shared that they at times were resentful of their partners due to their lack of interest and/or support for their child with autism spectrum disorder. Jeong talked about how her husband didn’t care about their three children or their varied diagnoses of ASD, ADHD, and anxiety. Due to his lack of interest, she had to take all of the children to their therapy and doctor’s appointments on her own. Jeong also mentioned that not only was her husband unsupportive, he had an extramarital affair during the most stressful time of her
adjustment to ASD. She shared that if given the chance to do things over again, she may have never married her husband or may have left him.

My circumstances were really hard and difficult. And before I thought when a man cheated, there was something wrong with the wife. And since he’s had an affair, I knew that that wasn’t the case. (laughter) I lived really hard. I did everything. But he still had an affair. I became more mature, more understanding of other people. God gave me a bigger heart.

Soojin shared that her husband did not have much interest in special needs and also had much more difficulties accepting their son as needing extra attention and help. Although her husband was helpful in a lot of different ways, such as supporting her decision to cut off all relations with her mother-in-law, when it came to learning and being proactive about the diagnosis of ASD, he was not interested.

And I think the other one is that my husband didn’t have much interest. Like if he was healthy, ok. You know? And he didn’t even want to know about the special needs. Like, until right now, he understood that our son was special, but he doesn’t try to search how he could help, he just want to, sometimes he told me that he wants to treat him like he’s normal that’s how he needed to survive here. But it’s a little bit difficult for me because it seems like I’m the only one that worries about him. And sometimes I’m thinking I’m having too much of an obsession about this.

The participants mentioned having feelings of jealousy and resentment surrounding reciprocal relationships and not being able to have typical experiences with
their children who have ASD. They also mentioned the sacrifices that have been made for their children and how it had affected their lives. Even though most of the participants stated they were used to the idea and did not think about it as often, it was still present.

Cultural Differences during Adjustment

The final theme that emerged from all of the participants was cultural differences during adjustment. In the current study, cultural differences mainly focused on how South Korean immigrants viewed the special needs population and how the participants identified with each culture. It also looked at the cultural differences that affected the participants’ experiences, coping skills, and adjustment between their immigrant culture and host culture. The sub-themes were a) bi-culturalism and b) prejudice. The following section was a closer look at each participant’s experiences. Almost all of the participants reported identifying as bi-cultural, and three participants reported feeling prejudice from within their own culture.

Bi-culturalism. Five participants in the current study reported that balancing two cultures proved to be difficult during their adjustment to their child with autism spectrum disorder. Yoosun, Eunsook, Haeshin, and Soojin all identified with the American culture more than their Korean culture with Jeong feeling split between the two. Yoosun explained that the Korean culture was “shame based” and growing up if you did not fit into a “mold” you were not going to be successful.

I was groomed and raised to do that and to a certain extent I achieved that. I went to the school, I got married, and you know we graduated from good colleges and
had good jobs in tech and all of that and then all of a sudden, I’m going to continue, I’m going to perpetuate the culture in which I grew up in, with my children. But all of a sudden I realize that my child is not gonna be able to fit that no matter what I do.

Yoosun identified with the American culture more and indicated, “I’m glad I’m Korean American” referring to having to advocate for special needs services for her son. She also mentioned that because she was Korean and belonged to a Korean church, she felt pressured and responsible to not let her church obligations go in fear of “disappointing” them. Due to the struggles of bi-culturalism, Yoosun mentioned that it took longer for her to decide what needed to be done for her son and to prioritize her child as opposed to what the needs were of the collective group.

Eunsook stated that since she immigrated during high school, she found herself making major decisions on her own without the help of her parents due to limitations in language and knowledge. She also felt that there was not a need to gravitate back toward the Korean culture and did not feel that it was important for her daughter to know or understand about the culture.

And also because of the language issues, um, my parents didn't speak a lot of English so we kinda had to take on all the decision making like what to major in college and so forth, ourselves. And I think that's kinda different because in Korea pretty much we're kinda told, either told or geared, like the road was already there, so I think that was kind of the difference. And kind of the difficulty that we had to face.
Eunsook also reported that the Korean culture was designed for limited acceptance. She stated that it was a lot more depressing to have a child with special needs as you are looked down upon as less in the Korean culture. Although she had come to a place of much acceptance, deep down inside she sometimes had a tendency to hush and quiet her daughter in public in order to avoid judgment or questions from the Korean population.

Haeshin had a slightly different view on bi-culturalism. Because she immigrated at a younger age and was raised more so as an American, she found herself gravitating more toward the Korean culture as she got older. She also found the urge to expose her daughter with ASD to the Korean culture and to learn about it. Her husband, who was also Korean, immigrated to the United States at a later age but did not feel the same about the Korean culture and rejected most of its beliefs.

I don’t know, I think just wanting to know and understand my parents more or where I came from or you know there’s definitely a culture that you know, it’s very different although I hold onto, you know like we do Christmas we do Thanksgiving we celebrate Easter all those things, we love doing all that. But I think it’s good you know for my daughter to be exposed to like you know Korean Thanksgiving what is that, like you know, or you know different things like that it’s just more fascinating.

Jeong shared that due to immigrating at an age considered to be an adult, she was pressured to discontinue her education and to begin making money to financially support the family. She admitted that she resented her younger siblings who were not pressured
at all in the same way that she was. Even at the time of immigration, she did not consider herself to be a very traditional person so she had a difficult time giving up her goals and dreams for the sake of the collective, her family.

Yeah so after we immigrated, I had to help my parents, as the eldest daughter, I had to get a trade that was going to make money, like a beautician or something. And that pressure to have to make money and help support the family was really hard on me. I wasn’t that traditional of a person and just because my parents were having a hard time, I wasn’t ready to give up my whole entire life for them. So I had a really hard time with that pressure. There wasn’t any pressure on my younger siblings at all.

Soojin reported that being an immigrant stopped her from reaching out and finding more support for her son, as she did not feel welcomed in groups predominantly joined by native English speakers. She described that she felt personally segregated and always wondered what she was missing out on. Soojin also explained her interesting insight regarding her bi-culturalism. She shared that if she had spent all of her life in Korea with the rest of her family and her in-laws, then maybe she would not be as open minded about disabilities and special needs as she is now. She believed that having the same views and beliefs about special needs may have possibly contributed less stress and created less discord among her family members.

That’s how they think about it. A lot of old people. So it’s, until right now, a lot of, in Korea, a lot of people they hide at home, and everything. So, it may be I don’t have an open mind about disability if I would’ve lived in Korea. I don’t
know if it would be better, but not so much stress you know, not (pause) it’s because I have always have something in my heart that bothers me when I’m thinking about everything that happened with my husband, my mother-in-law, until right now, I don’t really like to talk to her too much. When my husband talks about his family, I tell him I don’t want to talk about that, something like that. I try to avoid his family, so maybe it would be something different situation.

**Prejudice.** For Myung, Haeshin, and Soojin the second sub-theme of prejudice was reported. Although they were all of the same ancestry and ethnicity, these three participants reported feeling prejudice from their own people and culture due to having a child with special needs.

Myung shared that the prejudice he felt came from avoidance. When asked if he avoided Korean people, he in turn expressed that he found Korean people avoided him and his son. He expressed that he does not condemn those families who are attempting to “protect themselves” by not associating with his son but he does “hugely appreciate” those families that “make the effort and who clearly do have a heart and want to even know what’s going on with my son at the expense of potential social embarrassment.”

I find Korean people avoiding us and that’s even (long pause) to a certain degree even family. And I don’t think it’s meant to be malicious, I think it’s just, once again, it’s because of a lack of education on like autism, in this case. And in some circumstances, I think (pause) and I don’t know if it’s a ethnic cultural thing, I think some people or some families have a tendency to really wanna pursue, ok well, what is this all about versus some kinda saying I need to protect my own
family, my family comes first. I can’t blame them for that, does it make me upset that they don’t make an effort, maybe a little bit, but I can’t blame them for that because who’s to say I wouldn’t have been the same way.

When asked about gravitating back toward Korean culture, learning more about it and exposing Mark to it, Myung responded with a very passionate answer of no. He explained that he does not agree with much of the culture and does not appreciate its superficiality.

I think I’m a little bit different in that, but you know having been exposed to Korean culture, uh, yeah I don’t necessarily agree with it. There’s, a lot of stuff is very superficial. And um, yeah, that’s one thing I can confidently say I cannot stand is. I am very big into authenticity. Superficiality just has no room in my life whatsoever.

Haeshin shared that she wanted to gravitate back toward the Korean culture in order to expose her daughter to it but there were some parts of the culture which she was not fond of. One of those aspects was how her in-laws treated Mary and clearly segregated the family by placing her husband, their son, on a pedestal. She reported that her mother in-law wanted to do everything for her son when she visited and instead of taking an interest in her granddaughter, she made it clear to Haeshin that she was at the bottom of their family’s hierarchy. She also stated that her mother-in-law had asked when she would be returning to work to help financially with the family instead of leaving all of those responsibilities to her son.
Soojin indicated that her prejudice came in the form of gossip. When she used to drop Logan off at Korean school and Nick wanted to walk with him, she would notice other parents and children whispering and pointing at Logan. She was uncertain of the exact words spoken but stopped attending Korean school because she did not want Nick to be exposed to that type of behavior.

But of course I feel much more comfortable in American community than Korean community. Because um, Korean community talks a lot. Even when it’s an American community, even kids, they try to talk to my son. They seem like they understand that he’s special, you know like, here you, school has special kids in class, so maybe it seems like some of the kids already know that they need to be more nice with the special kids, but Korean community, they don’t talk but they don’t try to talk with him, but they talk to each other, like look at this you know? I can see that, so that’s really uncomfortable, yeah.

Overall, the participants acknowledged that they experienced unpleasantness as related to the Korean culture and how it viewed the special needs population. The participants learned how to combine their host culture with their immigrant culture and lead a bi-cultural life with the best of both worlds.

**Summary**

This chapter presented the findings of the phenomenological research study investigating the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. The themes discussed in this chapter suggest common experiences among the interviewed South Korean parents who have a child with ASD.
The themes discovered were: a) Familial support during adjustment, b) Religion and spirituality as a way to cope, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness and e) Cultural differences during adjustment.

Chapter IV will further explore these themes in relation to the literature that has previously been presented regarding the South Korean immigrant parents who have a child with autism spectrum disorder. Limitations and suggestions for future research on the experiences of South Korean immigrant parents who have a child with autism spectrum disorder will also be discussed.
CHAPTER IV

DISCUSSION

The findings of the current study offered an in depth look at the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. As mentioned in the previous chapter, the outcomes and findings of the study resulted in themes. The major themes derived were, a) Familial support during adjustment, b) Religions and spirituality as a way to cope, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness and e) Cultural differences during adjustment.

The purpose of this chapter is to discuss the findings of this research. This chapter has seven sections. The first section of the chapter focused on the findings related to existing research completed about South Koreans, autism spectrum disorder, and immigration. The second and third sections elaborated on the implications this particular research study had on the field of counselor education and the mental health system. The fourth section focused on the implications for future research and suggestions. The fifth, sixth, and seventh sections focused on limitations, the researcher’s reflections and thoughts, and the overall summary, respectively.

Findings Related to Existing Literature

The current study investigated the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. The main research question was: What are the experiences of South Korean immigrant parents who have a child with autism spectrum disorder? The results of this study suggest five major themes supported by the data provided by each participant. The themes were: a) Familial support during
adjustment, b) Religion and spirituality, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness, and e) Cultural differences during adjustment.

**Familial Support during Adjustment**

All of the participants reported some degree of support related to their adjustment from family members. Some of them stated receiving a lot of support while others stated receiving limited or no support. The existing literature is discussed below supported by the sub-themes.

The current literature stated that parents of children with disabilities may require additional support to address their own psychological worries regarding the future (Esbensen, Seltzer, & Greenberg, 2006). The presence of a child with ASD is a significant source of stress that may affect some aspects of parental adjustment and family functioning (Brennan & Brannan, 2005; Deater-Deckard, 2014; Dunlap, Plienis, & Robbins, 1988; Ekas, Lickenbrock, & Whitman, 2010; Hallberg, 2014; Pisula, 2011) due to the different symptoms and needs the child has (Bolton, Golding, Emond, & Steer, 2012; Dewey & Kaminski, 2002; Ricci & Hodapp, 2003). Parents with children diagnosed with ASD experienced worse anxiety and depression (Gau et al., 2011) and higher levels of fatigue when compared to other parents of typical children and children with other disabilities (Smith et al., 2010).

The literature also reported that the stress parental caregivers experience affected other family members when caregivers were unable to adequately process their stress related to emotions and actions (Brannon & Heflinger, 2001; Freedman, Kalb, Zabolisky, & Stuart, 2012; Hartley, Barker, Seltzer, Greenberg, & Floyd, 2011; Pottie &
Ingram, 2008) denoting that receiving support may have saved the rest of the family members from experiencing stress. Because parents can experience these stresses at different points along their journey (Farmer, Burns, Angold, & Costello, 1997; Hallberg, 2014) it was important for these parents to receive continuous support (Fisman & Wolf, 1991; Keen, Couzens, Muspratt, & Rodger, 2010; Minnes, Perry, & Weiss, 2014).

Pearson and Chan (1993) reported that parenting stress in mothers with disabled children showed that social support works as a catalyst for building up a greater defense system against the effect of unpleasant surprises along the way. Immigrants were more likely to rely heavily on the social support of the extended family rather than that of friends, neighbors, coworkers, or professional agencies (Al-Issa & Ismail, 1994; Gore & Aseltine, 1995; Thomas & Choi, 2006).

The findings of the study support the literature when it comes to needing to receive a lot of support from parents, family, and the community. The findings reported that parenting a child with ASD or special needs required more support in order to keep the family functioning so receiving this support was an integral part of the participants’ adjustment and coping.

In regards to receiving limited or no support, the literature stated that the lack of social and support networks lead to social isolation and stress, particularly when the immigrants encounter difficult situations (Hong, 1989; Shon & Ja, 1982). Social support was identified as a fundamental need and resource which enhanced personal security and mental well-being for the South Korean population (Al-Issa, 1997) and played an important role in maintaining the mental health of these parents (Fisman & Wolf, 1991).
The literature reported that family assistance was the most important source of support and help for psychological, emotional, spiritual support, and immigration orientation (Min, 1998).

The findings of the study supported the literature by revealing that those participants who received limited to no support had a more difficult time adjusting and coping with their child. Those participants were also more susceptible to depression and reported suffering from other mental health issues.

**Religion and Spirituality**

Another major theme discussed by the participants was the topic of religion and spirituality as a method of coping. All of the participants except for one stated that religion and spirituality played a role in their coping with the diagnosis or their child. Although not all of the participants utilized religion and spirituality in a positive light, it however played a role in their adjustment.

**Finding comfort, peace, and hope.** The literature reported that attributions to fate or God’s will were related to better adjustment while coping with difficulties (Helgeson, Mickelson, & Wroble, 1999). The literature also stated that religiousness, generally speaking, is more closely and consistently linked to active coping (Pargament & Raiya, 2007).

Joshi, Kumari, and Jain (2008) stated that religious beliefs can shape a person’s psychological perception of pain or disability as they create a mindset that enables the person to relax and allow healing on its own. Religion can play a major role and can provide hope in despair. As the participants stated, they were able to find hope and
experience deep peace even in the midst of mental distress (Underwood & Teresi, 2002). Participants who were religious found that engaging in positive religious coping behaviors were helpful. These behaviors include trying to find a lesson from God in the stressful event, doing what one can do and leaving the rest in God’s hands, seeking support from church members, thinking about how one’s life is part of larger spiritual force, looking to religion for assistance to find a new direction for living when the old one may no longer be viable and attempting to provide spiritual support and comfort to others (Joshi, Kumari, & Jain, 2008).

**Blaming and anger.** Ellis (1980) had claimed that religiousness is accompanied by irrational thinking and emotional disturbance while Gartner (1996) found religion is associated with some forms of psychopathology, including authoritarianism, rigidity, dogmatism, suggestibility and dependence. The literature suggested that having religion as a coping mechanism could negatively impact the individual since their blind faith would not prepare them for real situations and hardships. Negative religious coping includes passive waiting for God to control the situation, redefining the stressor as a punishment from God, or as an act of the devil, and questioning God’s love (Pargament et al., 2004; Tepper, Rogers, Coleman, & Malony, 2001). Two participants in this section reported blaming and becoming angry with God during their adjustment. Although they both resulted in finding inner peace with religion, they initially shared experiencing anger leading to depression and further questioning. Although the two participants had faith, they felt victimized by God and placed blamed before being able to functionally cope.
Not a factor. The literature stated that other parents were cited as the most common source of support, surpassing spouses, family members, friends and neighbors, written sources such as books, web pages, and religious communities (Mackintosh, Myers, & Goin-Kochel, 2005). An existing piece of literature studied mothers coping with their children who were diagnosed with ASD. The literature reported that although prior research indicated religion in and of itself to be important as related to coping, the participants in this particular study reported that belonging to a specific religion was more of a beneficial method of coping (Kuhaneck, Burroughs, Wright, Lemanczyk, & Darragh, 2010). All but one participant reported that religion played a role in their adjustment. This participant stated being open to religion but found that being realistic and accepting the diagnosis of her child was easier to cope with rather than turning to a deity.

Guilt and Shame over Diagnosis of Autism Spectrum Disorder

The next major theme discussed in this study was the theme of guilt and shame after the diagnosis was received. As a parent, receiving the diagnosis of ASD, or any disability, can be a turning point. While most parents gird themselves for action leading to their own efficacy and a positive perception of their child (Chamak, Bonnian, Oudaya, & Ehrenberg, 2011; Fleischmann, 2004), others may experience less positive emotions and encounter difficulties in functioning and suffer from depression (Brannon, 2003; Chase, Landa, Piven, & Wzorek, 1991; Lainhart, 1999; Lee, Chen, Wang, & Chen, 2007). Existing research stated that a change in the perception of the parents following diagnosis can enhance their abilities to view coping as a positive challenge (Fleischmann,
The sub-themes explored the differences in the initial reactions of the participants upon receiving the diagnosis which lead to denial, guilt and self-blame, and cultural embarrassment.

**Denial.** The existing literature reported that when parents finally came to an understanding of their children’s developmental disability, the feeling was described as shock and disbelief accompanied by feelings of confusion, anger and despair (Babb, 2007; Pejlert, 2001). Three participants shared their experiences after receiving the diagnosis. They all agreed that receiving the diagnosis was difficult but coming to terms and accepting it was even more difficult. Some of the participants still talk about how they have moments of weakness and revert back to their original reaction of denial.

**Guilt and self-blame.** The existing literature stated that many scholars and investigators were deeply concerned about the detrimental effects of blaming parents for their child’s ASD, finding this positioning to be pejorative (Russo & Newsom, 1982), if not harmful (Rimland, 1964). Some parents of children with ASD attributed the cause of the disorder to heredity and environment (Helgeson, Mickelson, & Wroble, 1999). Self-blame attributions and attributions to the environment were related to worse adjustment among parents, but because the psychosocial adjustment of parents who have children diagnosed with ASD can be best compared to the parents of typically developing children, parental maladjustment as a contributing factor to the cause of ASD can be confidently ruled out (Dunlap, Plienis, & Robbins, 1988). When a child is diagnosed with autism spectrum disorder, parents experience a significant amount of stress (Dunlap, Plienis, & Robbins, 1988; Gerstein, C. M., Blacher, & Baker, 2009; Hallberg, 2014;
Hoffman, Sweeney, Hodge, Lopez-Wagner, & Looney, 2009; Schieve et al., 2011), and the loss of the child they hoped for involved more than grief for some parents (Babb, 2007).

The results of the study supported the literature with the participants expressing the loss of their idealized child as well as blaming themselves on somehow causing the ASD for their child. Many of the participants felt guilt for their typically developing child who had to endure the pain of not being invited to social events due to having a sibling with ASD and other missed milestones.

**Cultural embarrassment.** For the South Korean immigrant population, the choice of seeking professional help does not come so naturally for a variety of reasons such as social stigma (Shin, 2002). In order for the family to save face and be a functioning member in society, family affairs that are not deemed appropriate are kept isolated and hidden. Emotions are not made public when experienced as will power is utilized in order to overcome hardships (Kim, 1997). Members of the South Korean immigrant community believe that seeking therapy may carry a negative stigma not only for the client but also for the family (Johnson & Nadirshaw, 1993; Kim, 2002). Due to these cultural beliefs shared within this study and the existing literature, participants experienced backlash and hesitation from family and society when it came to their child with ASD. All of the participants except for one admitted to feeling cultural embarrassment and shared experiences of being embarrassed by their child with ASD (Kayama & Haight, 2014; You & McGraw, 2011). Because individuals with developmental disabilities are regarded with superstition and prejudice (Brown, Ouellete-
Kuntz, Lysaght, & Burge, 2011; Kayana & Haight, 2014; Rice, 2009), and the causes of these disabilities were attributed to ghosts, punishment for bad behavior of ancestors, or bad thoughts (Fan, 1999; Kim & Kang, 2003) it was important for the family to hide this from the public eye. Having a child with ASD could also tarnish the family’s name preventing others from wanting to marry into or associate with the family. Some participants felt embarrassed that their child did not fit into the mold of what was culturally expected of them and shared that the grandparents often had issues accepting their child due to the embarrassment of the disability.

**Bitterness**

The theme of bitterness covered areas of jealousy of parents with typical children, resentment of their child with autism spectrum disorder, or resentment of their partner. This theme exposed the participants’ feelings regarding their child with ASD and how it affected their views of other parents, their child, and their spouses.

**Jealousy of parents of typical children.** The literature stated that some parents expressed accepting the diagnosis of their child but not the consequences that followed (Babb, 2007) making the feelings of jealousy less but not obsolete. While sharing their jealousy of parents of typical children, it was revealed that having hope that intensive intervention can lead to a cure or a significant improvement in their children’s behavior (Siklos & Kearns, 2006). Another factor of jealousy, which the findings supported, was not being able to engage in joint attention, both parents giving the child attention, due to the child’s inability to reciprocate social cues to two individuals and respond appropriately among other deficits (Mash & Wolfe, 1999). Some of the participants
spoke about having to give up their careers due to the child’s needs and often missing the financial gains that a career would have provided. This caused feelings of jealousy of parents who were able to leave their child for others to care for without worry.

Participants expressed their emotions regarding their jealousy of other parents with only typically developing children. The jealousy ranged from wanting a typical career and parenting experience to worry and anxiety about their child with autism spectrum disorder. Since parents perceived the diagnosis of ASD as a loss of their child, not in the physical sense, but in the mental and emotional relationship, the participants were left with a sense of question and wonder. The participants who had multiple children, including special needs, had more difficulties as their typically developing child was a constant reminder of their loss contributing to their jealousy of parents who only had typically developing children.

**Resentment of the child with autism spectrum disorder.** The existing literature reported that caring for a child with a developmental disability is a source of psychological distress, with mothers of special needs children being at a greater risk of psychological distress than mother of children with typical development (Dyson, 1996; Hintermair, 2000). Parenting stress levels are higher in mothers whose children receive special education as compared to those with typical children not enrolled in special education (Lee, Chen, Wang, & Chen, 2007). The literature also stated that mothers of children with developmental disabilities had higher levels of anxiety and depression than mothers of typically developing children (Schieve et al., 2011).
When it came to careers, Schuster, Chung, and Vesta (2011) found that mothers’ work outside of the home was the most negatively affected by having a child with ASD. More than half of employed mothers who had a child with ASD, worked fewer hours in order to care for their child (Baker & Drapela, 2010). Although some participants in this study admitted to giving up their careers, the research did find a few benefits from working with decreased stress and time for contact with other adults being a few of them (Morris, 2014; Scott, 2010).

Dewey and Kaminski (2002) reported that having a child with autism spectrum disorder in the family placed non-disabled siblings at an increased risk of externalizing adjustment problems, as in aggression and external behaviors, and internalizing adjustment problems, as in depression. Siblings of a child with ASD needed a stronger support network compared to those of typically developing children and their siblings (Doppelt, Gross-Tsur, Pilowsky, Shalev, & Yirmiya, 2004). Not only were the typically developing siblings affected, the literature also exposed that interpersonal relationships within the immediate family, extended family, and community were also affected by the high demands and difficulties in raising a child with ASD (Dunlap, Plenis, & Robbins, 1988).

Although this was a difficult topic for the participants to admit to, two were able to genuinely express their feelings regarding their raw emotions about their child with autism spectrum disorder. Both of these participants shared that they would either not have had children or wished that they never had a child with ASD. The participants also stated resenting their child with ASD for inflicting emotional pain or stress on their
typically developing siblings. Due to all of these factors, the participants had difficulties adjusting to the high demand of their children with ASD and having to sacrifice for them.

**Resentment of their partner.** The literature stated that finding emotional support from spouses and social environments was reported as one of the most difficult tasks for parents (Pearson & Chan, 1993). Examples of social support include support from one’s spouse, family and friends, community programs, professionals, and the availability of leisure time (Siklos & Kerns, 2006). Without their spouses providing support, the participants were not able to engage in leisure time, which contributed to their struggles and depression. A stronger indicator of healthy adaptation and coping in the family was the amount of perceived support the mother received from her spouse (Siklos & Kerns, 2006). Due to the higher levels of increased stress, parents of children with ASD experienced higher divorce rates (Freedman, Kalb, Zabolysky, & Stuart, 2012; Hartley et al., 2011).

The resentment of their partners surrounded the participants talking about their spouses and the lack of support provided while adjusting and coping after the diagnosis of ASD was given. The participants in this section expressed that they had to cope and figure out treatment on their own due to the lack of interest and support from their spouse.

**Cultural Differences during Adjustment**

Due to the lack of research regarding this population, it makes it difficult for clinicians and other professionals within the helping profession to provide adequate and
necessary services to South Korean immigrants. This final theme explored bi-culturalism and prejudice experienced from within the same culture as the participants.

**Bi-culturalism.** The participants in this sub-theme shared the difficulties of balancing two cultures during their adjustment. Immigration is a difficult transition with psychological and behavioral affects being worse in the first few years before improving (Lu, 2010; Titzmann, Silbereisen, & Mesch, 2014). For the South Korean population, the mean duration between the onset of the problem and first therapeutic consultation was 5.3 years (Shin, 2002) demonstrating South Koreans’ reluctance to seek therapies for themselves (Jo et al., 2011). Language was also a barrier with research stating that learning the host culture’s language lessened the overall negative affects associated with immigration (Brenick, Titzmann, Michel, & Silbereisen, 2012; Neto, 2010). The South Korean culture is a culture based in shame which is why issues were dealt by long-term solitary coping, family involvement, and extensive utilization of the traditional Asian health care system and primary care services that led to a delay in contact with mental health services and entry into treatment (Shin, 2002). Although it is understood that these social factors affect their inclination to seek services, it is important for mental health professionals to understand help-seeking behaviors that may be deterring or delaying some immigrant populations from receiving timely, appropriate mental health care (Chu, Hsieh, & Tokars, 2011; Shin, 2002).

The participants mostly identified with their American host culture but a few found themselves more interested in gravitating back toward their South Korean roots in order to better understand their parents and traditions, which supports Tartakovsky (2009)
who stated that the individual’s identity with their culture prior to immigration predicts how they’ll identify with their new host culture. Some of the participants expressed that being of South Korean descent stopped them from reaching out and finding resources and support fearing not fitting in with the host culture. Some participants shared that treatment was delayed due to the lack of access they had to different services as well as the fear of not being accepted by their families and culture.

**Prejudice.** This sub-theme surrounded the prejudices the participants experienced from other South Korean individuals. The research stated that many Asian people hold stigmatized attitudes toward developmental disabilities and people with these disabilities (Fan, 1999; You & McGraw, 2011) and descriptions of the developmentally disabled population from the media contributed to clients avoiding services as they may be viewed as violent, dangerous, and pathetic (Shin, 2002). The prejudice also came in the form of causing problems for the family if the community became aware of the client’s need to seek professional help (Chu & Sue, 2011; Johnson & Nadirshaw, 1993). However small these encounters may be, the collection of these encounters can provoke added stress, which negatively affects coping skills (Chen & Spencer, 2012; Spencer, Chen, Gee, Fabian, & Takeuchi, 2010). These encounters were also attributed to negatively influencing both physical and mental health (Kim, 2013) as well as other factors such as income and educational level (Kim & Keefe, 2010). Due to having to overcome these challenges, research showed that first generation immigrants were physically and mentally better off as compared to non-immigrants (Chen & Spencer, 2012; Herman, 2004; Neto, 2010).
One of the participants explained how he began to notice that other South Koreans were avoiding him and his family in order to not have contact with his son diagnosed with autism spectrum disorder. Other participants experienced prejudice within their own families and in the form of public gossip. Since it is believed that the group’s well being is much more important than that of the individual for the South Koreans, the more prejudice the participants felt, the less they were likely to want to share and interact with others in order to save face.

**Implications for Counselor Educators**

The current research is a phenomenological qualitative study involving only six participants and the results are not generalizable. However, the data gathered support the implications of the research. Based on the findings of the current research, there are a few implications for the field of Counselor Education and how future counselors can be better prepared to successfully work with populations such as South Korean immigrants who have a child with autism spectrum disorder. The areas are: a) An increased awareness of multicultural and immigrant issues, b) An increased awareness of the special needs population, and c) Providing more diverse internship sites to increase exposure.

As previously discussed in Chapter III, most of the participants stated that they were unable to reach out and find resources due to their disconnect to the host culture and feeling isolated. If future counselors had an increased awareness and understanding of multicultural and immigrant issues, regular outreach can be completed and maintained in homogenous areas in order to continue spreading the word of services. Without the
increased awareness, there would not be exposure to the needs of the Asian community and would not spark interest in current counselors to spend their time and efforts in this manner of prevention. During the degree process, there are not many opportunities to learn about how to provide outreach to immigrant and minority populations. Also, if properly exposed and trained, future counselors would be well versed in providing guidelines according to the cultural beliefs of the client. These skills would aid in forming rapport, trust, and giving the client a sense of understanding to keep them returning for further help.

As mentioned about the minority and immigrant population, the same awareness and training should be provided regarding the special needs population. With the increase in ASD and other developmental disabilities, it is in the counselor’s favor to have knowledge of or at least exposure to this population in order to provide the appropriate guidance, ideas, and referrals. Parents of special needs children are a unique culture in and of itself that does not receive a lot of support.

With the proper training, education, and exposure, future counselors and counselor educators can be further diversified and ready to educate other students. The added education will also prepare them to have more meaningful therapeutic relationships with both the culturally diverse and special needs populations. The treating therapist must consider alternatives that the client may be seeking such as herbal medicine, acupuncture, holistic therapies, etc. in order to help address his/her current mental ailments (Chu, Hsieh, & Tokars, 2011; Jo, 1999). In order to understand fully the
client’s personal and cultural beliefs about the effectiveness of treatment, these branches of medicine and methods of treatment must be explored.

**Implications for the Mental Health System**

The underuse of mental health services by Asian immigrants will not be resolved unless restructuring of the mental health services system is linked to more efficient service delivery (Abe-Kim et al., 2007; Shin, 2002). It is vital that their services be made readily available for the Asian population, as the individuals do not seek it out (Chu, Hsieh & Tokars; Nguyen, 2013). The design of interventions may help to be more comprehensive and connected with the needs of the population whether the target is low-income, multiethnic, or newly acculturating populations (Tien, 1992). The services can be available to the Asian populations where they are present in daily living, where a break from routine is not needed to avoid raising red flags for their families. These areas could be their place of education, church, or medical offices. Questions regarding mental health could be made a part of intake questionnaires for those seeking medical attention and a mental health professional could be present for those seeking treatment for common psychosomatic symptoms and issues. Translators may also be readily available to allow a comfort level for the newly immigrated and those who have not yet acculturated. Implementing interventions and therapeutic locations around the needs of the Asian population may significantly diminish the anxiety surrounding the cultural embarrassment of seeking mental health treatment. Instead of waiting for the clients to seek out treatment, it would be a model of bringing the treatment to the client as a preventative model. Collaborating between mental health professionals and other care
resources that the population already frequents would be ideal in order to foster less stigma and will be better utilized by the Asian American population (Chu & Sue, 2011).

Beyond needing to increase Asian-language therapists, research pointed out the need for therapists who understand the culture with similar views (Zane et al., 2005). Having a therapist who not only speaks the client’s native tongue but understands their cultural views may contribute to clients remaining in treatment. Utilizing interventions which have been culturally adapted would be very helpful in building a connection with the client as well.

**Implications for Future Research and Suggestions**

Recommendations for further research is based on the need to further examine this topic of South Korean immigrant parents who have a child with autism spectrum disorder. Additional phenomenological studies including more gender-balanced participants should be conducted in order to get both the mothers’ and fathers’ views. Conducting the current research with a larger population across the United States would also shed light on South Korean immigrants’ experiences in suburban, urban, and rural areas of the country, as they may be vastly different.

Valuable research may be exploring the understanding of these parents’ biculturalism, how to process through the shame and guilt of the previous generations, and how to provide proper support for these parents who have a child with ASD. Further research should also consider training counselors to work with extended families who may be less acculturated than the parents who have the child with ASD.
The further needed research can be done qualitatively through extensive interviewing. Although this suggestion may be cumbersome for the researcher, a qualitative interviewing process will yield deeper and valuable information for this type of subject matter as compared to a quantitative questionnaire. These results can be compared to one another to observe the differences. As far as training future counselors, an assessment could be made of counselors’ current knowledge and comfort regarding the Asian and special needs populations. This may shed light to current educators and supervisors as to which areas need to be further addressed in order to provide a more educationally rich experience and to better prepare them for internships.

**Limitations**

In order to consider the implications of the results found within this study, the limitations must be taken into consideration. There were a few items which limited this research. The first is related to the gender among the six participants as only one of the participants was male. This may have altered the overall findings as most of the responses were from the mothers’ points of views and are largely different than those views of the father in both experience and perspective.

The second limitation that was experienced was the time restraints. Because the time between the two interviews varied from one month to nine months, depending on the participant and how quickly the researcher transcribed the initial interview, this may have altered and varied the participants’ responses. The lapse in time may have given the participants time to further process, forget about their initial answers and repeat themselves, or give completely different answers as compared to their initial interview.
Also depending on when the interviews were scheduled, the participants could have felt hurried, tired, or overwhelmed which would have affected their openness and willingness to respond in depth. The responses would only provide a snapshot dependent on the conditions occurring during that time.

A third limitation that may have affected the research was the participant’s need to provide desirable answers. Due to the new relationship between the researcher and the participant, each participant may have felt the need to provide answers they believed the researcher to be seeking. The participants may also have held back their responses or not divulged in full detail in fear of judgment or shame.

**Researcher’s Reflections and Thoughts**

Throughout the process of gathering data and completing the interviews, the researcher was pleasantly surprised by the openness of the participants, which was unexpected. Although the researcher needed to ask questions that would be deemed socially inappropriate, especially for an initial meeting, such as asking about marital relationships and issues regarding extended family, the participants were forthcoming and willing to share for the sake of the research in hopes that it would help other parents in similar situations.

During the months spent gathering and analyzing the data, the researcher spent considerable time reflecting on her own life and her views of being a South Korean immigrant parent who had a child with special needs. The researcher found herself relating to many of the participants and also realized that she was indirectly receiving support through their experiences and resources shared. This reflection has led to growth
both as a clinician and as a researcher. As a clinician, it helped to provide further understanding of South Korean immigrant parents who have a child with autism spectrum disorder and how to better assist and meet their needs. As a researcher, it proved a bit difficult to find willing participants as a lot of South Korean immigrants were not emotionally prepared to share their experiences. For those who did agree to participate, they appeared to be more at ease as the researcher was of South Korean descent and shared immediately that the researcher also had a child with a disability. The disclosure may have helped the participants to open up as a parent to another parent rather than a parent to a researcher.

**Summary**

The purpose of this study was to begin to delve into the experiences of South Korean immigrant parents who have a child with autism spectrum disorder as they deal with acculturation, searching for services and resources, and attempting to gain support while juggling two cultures. In order to gather information, the researcher utilized the phenomenological research method and interviewed six South Korean immigrants who were predominantly raised in the United States and had a child diagnosed with ASD. The findings yielded from this research will contribute to the literature in the areas of South Koreans, immigration and acculturation, and autism spectrum disorder. From the analysis of the gathered data, six major themes were discovered: a) Familial support during adjustment, b) Religions and spirituality as a way to cope, c) Guilt and shame over diagnosis of autism spectrum disorder, d) Bitterness, and e) Cultural differences during adjustment.
As a result, the themes and information gathered can be utilized to further study South Korean immigrants who have special needs children. The research can also extend to other Asian and minority populations who share the same views of shame, guilt, and embarrassment toward individuals with special needs. The researcher hopes that the current study will build momentum and peak interest and curiosity in regards to South Korean immigrant parents who have a child with autism spectrum disorder. This study can also guide other researchers, scholars, and counselors to further study this area and to become more aware of not only South Korean immigrants and their journey through acculturation, but also become more enlightened in the area of their adjustment to having a special needs child in a new host country.
APPENDICES
APPENDIX A

SCREENING CHECKLIST
Appendix A

Screening Checklist

Screening Checklist - This form is used to determine whether participants have met the eligibility criteria for the current study.

The following was a checklist of requirements of the parents:

Questions:                  YES    NO

1. Did you immigrate to the United States before the age of 18?

2. Do you believe that you have retained your culture through the celebrations of traditional holidays and the Korean language?

3. Are you fluent in understanding the Korean language?

4. Are you fluent in speaking the Korean language?

5. Do you celebrate Korean holidays and traditions?

The following was a checklist of requirements for the child with autism:

6. Is your child diagnosed with one of the following?
   - Autistic Disorder
   - Social Communication Disorder
   - Pervasive Developmental Disorder Not Otherwise Specified

7. Did a licensed professional diagnose your child?
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE
Appendix B
Demographic Questionnaire

Participant Pseudonym: ________________  Age: ______  Gender: ___

Marital Status: ________________  Occupational Status: ________________

Highest level of education completed: _______________________________________________________________________

Current place of residence: ______________________________________________________________________________

Religious/spiritual affiliation: ______________________________________________________________________________

Age when you immigrated to the United States: _______________________________________________________________________

Age when your child was diagnosed with autism: _______________________________________________________________________

Age of child when treatment began (if any): _______________________________________________________________________

Have you ever participated in mental health therapy for yourself? Why or why not? If yes, how long did it last and what did you like about it? _______________________________________________________________________

What type of treatment was utilized and for how long?

<table>
<thead>
<tr>
<th>Name/Type of Treatment:</th>
<th>Length of time in specific treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>-------------------------------------</td>
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<td>______________________</td>
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</tr>
</tbody>
</table>

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Name of children and ages:

Name: ___________________________ Age: __________

Name: ___________________________ Age: __________

Name: ___________________________ Age: __________

List all individuals who currently live in the household, age, gender, role, and their relationship to the child with autism:

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Age: _______</th>
<th>Gender: _______</th>
<th>Role: _______</th>
<th>Relationship: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ___________________________</td>
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<td>Role: _______</td>
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</tbody>
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APPENDIX C

OPEN ENDED INTERVIEW QUESTIONS
Appendix C

Open ended interview questions

1. Describe the types of cultural and life adjustments that needed to be made after immigrating to the United States.

2. During your adjustment to your child with autism, what types of coping mechanisms were utilized to overcome the difficulties, stereotypes, and stigmas?

3. How would you describe your experiences as a mother/father having a child with autism?

4. How did being of South Korean descent influence or impact your perceptions of diagnosis and treatment?

5. What do you wish you already knew about adjusting to having a child with autism spectrum disorder?
APPENDIX D
AUDIOTAPE CONSENT FORM
Appendix D

Audiotape Consent Form

WHAT ARE THE EXPERIENCES OF SOUTH KOREAN IMMIGRANT PARENTS WHO HAVE A CHILD WITH AUTISM
JULIE H. KWON, M.S., IMF

I agree to participate in an audio-taped/video taped interview about the experiences of South Korean immigrant parents who have a child with autism spectrum disorder as part of this project and for the purposes of data analysis. I agree that Julie Kwon may audio-tape/video tape this interview. The date, time and place of the interview will be mutually agreed upon.

__________________________________________    ________________________________
Signature                                      Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:

_____ want to hear the tapes   _____ do not want to hear the tapes

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be asked to sign after listening to them.

__________________________________________    ________________________________
Signature                                      Date

Julie Kwon may/may not (circle one) use the audio-tapes/video tapes made of me. The original tapes or copies may be used for:

_____ this research project   _____ publication   _____ presentation at professional meetings

__________________________________________    ________________________________
Signature                                      Date
Appendix E

Participant Letter

Date

Dear Potential Participant:

My name is Julie Kwon, a doctoral candidate at Kent State University in Kent, Ohio. I am currently working on my dissertation to complete requirements for a doctorate of philosophy degree in the Counseling & Human Development Services program. I have chosen to study the experiences of South Korean immigrant parents who have a child with autism spectrum disorder. In order to conduct my study, I am recruiting South Korean immigrant families who have a child diagnosed with autism spectrum disorder.

If you agree to participate in this study, you will then receive a consent form for participation, a demographic questionnaire, and an audio consent form from the IRB via postal mail. You will be asked to complete and return these forms in the self addressed and stamped envelope back to the researcher.

As a participant in this study, you will be asked to participate in two to three interviews ranging from face to face to phone calls lasting anywhere between 30 to 90 minutes. The interviews will be scheduled at a time that is most convenient for you and audiotaped. All audiotapes will be destroyed at the end of the research study and only limited demographic information and a number will be included in the final write up for the results. All information will be kept in a secure location and will only be accessed by this researcher. After the data is collected, you will receive a copy of the transcript from the interview and will be asked for your input and accuracy. You will be asked to email any changes or comments that you may have regarding that interview to the researcher.

If you have any questions regarding this research, please feel free to contact me at 714-251-6405. If you have further questions or wish to speak to my dissertation advisors, Dr. Steve Rainey and Dr. Jason McGlothlin, can also be contacted at 330-672-2662. Please contact myself or either professor if you have any questions about this study or your participation in it. This research study has been reviewed and approved by the Kent State University Institutional Review Board. If you have any questions or concerns regarding the rules of research studies at Kent State University you may contact the Institutional Review Board at 330-672-0700.

Sincerely,

Julie H. Kwon, M.S., IMF
Doctoral Candidate
Appendix F

Flyer

Are you a South Korean immigrant?

Do you have a child that has been diagnosed with autism spectrum disorder?

If you answered ‘YES’ to all of the above questions, you may be a potential participant for a research study fulfilling the requirements for a doctoral dissertation.

If you are interested in finding out more or participating in this study, please feel free to contact me!

Julie H. Kwon, M.S., IMF

714-251-6405

jkwon112@gmail.com
APPENDIX G

CONSENT FORM FOR PARTICIPATION
Appendix G

Informed Consent to Participate in a Research Study

**Study Title:** *What are the experiences of South Korean Immigrant Parents who have a child with Autism Spectrum Disorder*

**Principal Investigator:** Jason McGlothlin, Ph.D  
**Co-Investigator/Doctoral Student:** Julie H. Kwon, M.S., IMF

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary and you may withdraw participation at anytime throughout the research study without penalty. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

**Purpose:** The co-investigator/doctoral student is interested in how the South Korean immigrant parents experience their child with autism spectrum disorder. There is some research completed on South Korean immigrants, ASD, and experience of parents who have a child with ASD but a lack of research on the experiences of South Korean immigrant parents who have a child with ASD. The co-investigator/doctoral student would like you to take part in this study.

**Procedures**
You will be asked to participate in two to possibly three face to face interviews lasting anywhere between 30 and 90 minutes. The first interview will take around 90 minutes. During this time, you will be asked five open-ended question and unscripted follow-up questions related to your experience to having a child with autism spectrum disorder. After the initial interview is completed, the co-investigator/doctoral student will transcribe it verbatim. In order to ensure anonymity, you will be assigned a pseudonym for use within the results section.

The second interview will be executed in the same manner as the first interview. However, the co-investigator/doctoral student will take around 60 minutes for this interview. It will consist of follow-up questions. The follow up questions will be asked in order to further clarify answers provided within the first interview to gain more depth. It will also check for accuracy of the findings and explore any new thoughts that may have occurred to you in the meantime. After the second interview is completed, the co-investigator/doctoral student will transcribe the interview verbatim. The same pseudonym assigned during the first interview will be used to ensure continuity. A possible third 30...
minute interview will be scheduled via telephone in case the co-investigator/doctoral student needs to follow up on any of your answers from the first two interviews.

The co-investigator/doctoral student will come to your place of choice for these interviews for ease of access. You will also be asked to review the audio-taped transcription form each interview to check for accuracy and make any changes that you feel necessary. These reviews will be conducted on your own time. You will receive the transcripts form the co-investigator/doctoral student approximately 1 to 2 weeks after each interview is completed.

**Audio Recording**
All interviews will be audio recorded in order to accurately record what is said. In order to protect the confidentiality, all audiotapes will be destroyed at the end of the research study and only limited demographic information along with a pseudonym will be included in the final write up of the results. All information will be kept in a secure location and will only be accessed by the co-investigator/doctoral student. At the conclusion of the study, all material will be destroyed. Your participation in this study is strictly voluntary, and you can stop at any time. Should you decide to stop participation, your affiliation with Abundant Life Christian Fellowship church will not be affected.

**Benefits**
This research may not benefit you directly. However, your participation in this study may potentially inform professionals regarding coping skills within the family and potentially provide further information regarding working with parents.

**Risks and Discomforts**
Potential risks of this study are that you may recall difficulties surrounding your adjustment process during immigration. Other potential risks may include emotional responses to interview questions, and negative feelings resulting from raising your child with autism spectrum disorder. Some of the questions that you will be asked are of a personal nature and may cause you embarrassment or stress. You may ask to see the questions before deciding whether or not to participate in the study. If you become upset or uncomfortable, you may ask to take a break or discontinue your participation in the study. In order to protect you from these risks, each participant will be given a list with the names and contact information of local therapists that you may contact for further exploration of your emotions. For your convenience, the listed therapists are within the same city as the church.

**Privacy and Confidentiality**
To protect your rights and privacy, all data collected involving you, including interviews, consents to participate, and consent to audio record will be kept in a locked secure location in the co-investigator/doctoral student’s office located at 1340 N. Acacia Ave., Fullerton, CA 92831 and only the researcher will have access. You will be asked to sign this consent form acknowledging your understanding of your right to privacy. Your name
will never be released and pseudonyms will be utilized in presentations and publications. No identifying information will be collected. Your signed consent form will be kept separate from your study data, and responses will not be linked to you.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

**Compensation**
At the completion of the first interview, you will receive a $30 Visa gift card. At the completion of the second interview, you will receive a $70 Visa gift card.

**Voluntary Participation**
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your participation in this research study.

**Contact Information**
If you have any questions or want to know more about this research project, please call the co-investigator/doctoral student at 714.251.6405. You can also contact the principal investigator, Jason McGlothlin, Ph.D., or the co-investigator/doctoral student’s faculty advisor, Steve Rainey, Ph.D., both at 330-672-2662. The research has been reviewed and approved by the Kent State University Institutional Review Board. If you have any questions or concerns regarding the rules of research studies at Kent State University, you may contact the Institutional Review Board at 330-672-2704. You will receive a copy of this consent form.

**Consent Statement and Signature**
I have read this consent form and have had the opportunity to have my questions answers to my satisfaction. I voluntarily agree to participate in the study. I understand that a copy of this consent will be provided to be for future reference.

_________________________________________  _______________________
Participant Signature                           Date
APPENDIX H

RESEARCH PARTICIPANT RECEIPT
Appendix H

Research Participant Receipt

Kent State University (KSU) is required to maintain the confidentiality of information about research study participants while still complying with record keeping requirements of the State of Ohio, the Internal Revenue Service (IRS), and funding agencies. This form serves as documentation of receipt of compensation by individuals participating in research studies conducted by KSU personnel and is used to obtain information to comply with IRS reporting requirements.

1. I, ____________________________, have received/or am requesting compensation in the form and amount indicated below:

□ Cash $__________
□ Check $__________
□ Gift Certificate/Card $__________

Research Participant’s Signature ___________________________________________ Date ____________________

TO KSU PERSONNEL:
This form is to be used for research participants are receiving ≤$75 and the total of payments received for participation in the entire project < $600. If a research participant chooses not to provide their name they can choose to participate in the research without receiving compensation.

If a KSU check needs to be issued for payment, complete a Check Request form and submit to Accounts Payable, Schwartz Center Room 237. Do not attach a copy of this form to the request.

RPR-1 (revision 1.0)
For use when a research participant receives ≤ $75 and total payment for participation in research < $600
REFERENCES


Stahmer, A. C. (2007). The basic structure of community early intervention programs for


