MENTAL HEALTH SERVICE UTILIZATION BY CHINESE IMMIGRANTS: BARRIERS AND OPPORTUNITIES

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ABSTRACT

Mental health service underutilization by Chinese immigrants is a critical health and equality issue. This article reviews factors that contribute to low mental health service use across individual, family, cultural and system domains, and discusses ways to improve the responsiveness and equality of mental health care in Canada for Chinese immigrants.

Immigrants often experience an elevated levels of psychological distress in the period soon after immigration (Beiser and Edwards 1994). Job insecurity, altered family dynamics, economic hardships, and cultural differences between the country of origin and the host country all contribute to heightened psychological stress during the first years following immigration (Ritsner and Ponizovsky 1999; Tang, Oatley and Toner 2007). Paradoxically, studies in North America have repeatedly confirmed the underutilization of formal mental health services by Chinese immigrants (Bui and Takeuchi 1992; Chen and Kazanjian 2002; Sue and Sue 1999; Tsai, Teng and Sue 1981; Matsuoka, Breaux and Ryujin 1997; Kung 2003). Studies have documented that by the time Chinese immigrants finally receive formal mental health treatment, they tend to present more severe symptoms compared to non-immigrant users (Snowden and Cheung 1990; Chen et al. 2003), are harder to treat, and frequently require lengthy inpatient hospitalization.

What may contribute to gaps between mental health needs and service utilization among Chinese immigrants? Literature has shown that factors explaining service underutilization are multifaceted, extending across individual, family, cultural and system domains. The first of these is the *cultural explanation of mental illness.* Cultural beliefs regarding the cause of mental disorders greatly affect service utilization. The aetiology of mental illness includes moral, religious or cosmological, physiological, psychological, social and genetic factors. From a moral perspective, mental illness is deemed to be a punishment for "misconduct" against Confucian norms, the principles defining interpersonal relations and personal behaviours (Kramer et al. 2002; Lin and Lin 1981). As implicated in the religious or cosmological perspective, mental illness has also been seen as representing the wrath of supernatural spirits (Gaw 1993; Kramer et al. 2002; Koss-Chioino 2000) or ancestors (Barnes 1998; Lin and Lin 1981) induced by patients or other family members. In a Toronto study, Chinese immigrants who subscribe to supernatural beliefs tend to hold a negative attitude toward seeking professional help (Fung and Wong 2007). Traditional medical theory also plays an important role, in which all illnesses, both physiological and mental, are considered as imbalances of *yin* and *yang* (Lin and Lin 1981; Chung 2002; Ergil, Kramer and Ng 2002; Ma 1999). Psychosocial factors, such as major life events, are also considered to contribute to the onset of mental illness (Kramer et al. 2002; Lin and Lin 1981). Lastly, genetic transmission and the inheritance of the consequences of familial misconduct may be considered as causes of mental illness (Lin and Lin 1981). Each component described above is weighted differently, depending on the individual and context.

The second factor affecting Chinese immigrant's lack of treatment for mental illness is the experience of *shame and stigma*. Stigma attached to mental illness may prevent Chinese immigrants and their families from seeking mental health services (Chung 2002; Gaw 1993). Although psychiatric stigma is a well recognized issue across cultures, it may have more severe and decisive consequences among the Chinese (Sue and Sue 1987). The negative effect of stigma among the Chinese is often reflected in a low rate of mental health service utilization, excessive concern about confidentiality, reluctance in using insurance coverage, and absolute refusal to use professional help in the face of obvious psychiatric symptoms (Gaw 1993).

Literature suggests that given the collective and family-centered cultural orientation in Chinese society, an

individual's mental illness taints family grace, and naming and shaming extends to ancestors (Kramer et al. 2002; Lin 1981). Furthermore, seeking mental health services is not only considered to bring shame to the individual, but also to his family members, their ancestors and their offspring (Gaw 1993; Leong and Lau 2001). Fear of "losing face" and being derided is common among Chinese families with mentally ill members. This, in turn, leads to a denial of the existence of mental illness, or attempts to mask the problem with a socially acceptable label. Clearly, family-oriented stigma prevents individuals with mental health needs from receiving timely and appropriate assessment and treatment (Gaw 1993; Lin 1981).

Symptom presentation also influences the use of mental health services. Chinese people tend to perceive mental disorders as organic disorders (Lin and Cheung 1999; Uba 1994). Often, Chinese patients express their psychological problems in a psychosomatic form, which can explain why *somatisation* and *neurasthenia* are commonly observed in Chinese communities. Somatisation is "the presentation of personal and interpersonal distress in an idiom of physical complaints together with a coping pattern of medical help-seeking" (Kleinman et al. 1986, 51). Consistent with the Chinese cultural context, somatisation allows one to suppress the expression of potentially disruptive and ego-centered experiences in order to maintain the harmony of social relations. Transferring the mental disorder to a physical complaint also meshes with the desire to avoid the strong stigma attached to mental illness. Additionally, somatisation is consistent with the perceived legitimacy of seeking help for bodily complaints rather than psychological issues (Kleinman 1981).

Somatisation also contributes to the popular use of *neurasthenia.* Originating in the U.S. in the 1860's, neurasthenia was introduced into China in the early 1900s and has been widely accepted and recognized in Chinese communities (Kleinman et al. 1986; Lee 1998; Flaskerud 2007). Neurasthenia is a complaint of increased physical or mental fatigue that often reduces individual performance and functioning (World Health Organization 1993). It often is accompanied by diverse somatic and psychological symptoms, ranging from headaches, dizziness, fatigue, insomnia, chest discomfort, and gastrointestinal problems, to depression, anxiety, irritability, and anorexia. Often, psychological issues are secondary to physical problems (Schwartz 2002). Although neurasthenia was eliminated from the U.S. *Diagnostic and Statistical Manual* as of 1980 due to its indiscriminate features, laymen and clinicians in mainland China, Hong Kong and Taiwan continue to apply this term (Flaskerud 2007; Schwartz 2002).

Help-seeking preference is also influenced by Chinese culture. Often, family, rather than the individual with mental illness, makes the treatment decisions (Lin and Lin 1981; Lin and Cheung 1999). Lin and Lin (1978) studied help-seeking patterns among Chinese Canadian families having a member with psychotic disorders and identified a hierarchical pattern that has five phases.[1] Notably, the first three phases, seen as a protracted "intra-familial" and "pre-psychiatric" stage, can last from several to over 20 years. When the family and other informal networks have failed to provide effective assistance, the formal institution is the last resort for a person with severe mental illness (e.g. psychotic disorders). Individuals with other types of mental illness, such as depression, neuroses or psychosomatic diseases, hardly ever approach mental health professionals, since these conditions are not regarded as mental health problems (Lin and Cheung 1999). Kung (2003) studied Chinese adults in the Los Angeles and discovered that 75% of respondents who had emotional needs did not seek help from any resource. Out of the 25% who ever sought help, family and friends appeared to be the major source (20%). Moreover, among respondents who had a diagnosable mental disorder, only 15% had used mental health services.

Effect of discrimination. Facets of social context that are ever present in the lives of visible minorities are racism and discrimination. The perceptions of being treated unfairly or with disrespect due to one's race or ethnic background can play a role in the development of mistrust of service providers and subsequent reduced service use among minority populations (Spencer and Chen 2004; van Ryn and Fu 2003). Spencer and Chen (2004) have found that discrimination is associated with greater use of informal services and more assistance sought from friends or relatives, but not with use of formal services among Chinese Americans. Moreover, discrimination due to speaking a different language or having an accent was a significant contributor to the types of service one may use—Chinese Americans who have experienced language discrimination were 2.2 times more likely to use informal services and 2.4 times more likely to seek help from friends or relatives compared to those who did not experience such a treatment.

The lack of recognition by general practitioners. Somatisation or focusing on somatic symptoms of mental health issues naturally leads Chinese patients to consult their general practitioners, rather than seeking help from mental health professionals (Hsu and Folstein 1997). However, Chung and colleagues (2003) has indicated general practitioners, including those who speak the same language and share the culture, often fail to recognize and address treat their patients' mental health issues. Moreover, the provider stigma—which refers to physicians' fear of embarrassing their patients—further exacerbates negative feelings and inaccurate myths about mental illnesses, and delays proper referrals and treatment for patients who are in need (Chung 2002).

The use of complementary and alternative medicine also influences access to conventional mental heath services. Literature suggests that along with traditional Chinese health beliefs, indigenous medical practices exert important effects on the manifestation of symptoms and health behaviours among Chinese patients (Barnes, 1998; Kleinman et al., 1975, 1978). First, Chinese patients may rely on traditional Chinese medical practitioners, such as herbalists or acupuncturists for relief from emotional difficulties (Barnes 1998; Lin and Cheung 1999). In addition, as indicated earlier, the folk concept that mental illness is caused by supernatural forces and ancestral deeds is widely accepted in Chinese society. Therefore, folk healers such as shamans, physiognomers, geomancers, bonesetters and fortune-tellers are also commonly used in helping the Chinese manage daily stresses and treat illnesses (Gaw 1993). In Kung's study (2003), 8% of Chinese respondents with emotional problems reported that they had sought help from herbalists, acupuncturists, religious leaders or fortune-tellers. Compared to obtaining assistance from mental health clinicians or medical doctors, these alternative approaches are more likely to be solicited.

A lack of accessibility to linguistically and culturally appropriate mental health services has been proposed as one of the major reasons for service underutilization in this population. Perceived access to services was the most significant factor predicting negative attitudes towards seeking professional help among Canadian immigrants from mainland China and Taiwan (Fung and Wong 2007). Lin (1994) studied the length of treatment and dropout rate of 145 Chinese Americans treated by ethnic- and language- matched clinicians in an outpatient clinic and concluded that providing well-trained and culturally matched providers promotes the acceptance of mental health treatments among Chinese Americans and helps to ensure equal access and treatment opportunities.

OVERCOMING BARRIERS

As is true for other ethnic groups, mental health service utilization among Chinese immigrants is multidimensional and complex. Efforts ranging from micro- to macro- levels are needed to address the underutilization issue:

Assessment. Understanding the interconnections between mind, body, and spirit is essential for service providers and it will allow practitioners to provide more relevant, effective and efficient services. When assessing and treating Chinese immigrants, practitioners should be watchful for clients' somatic complaints. As studies have repeatedly demonstrated, unexplained somatic symptoms among Chinese patients may be a manifestation of mental health issues (Lin and Cheung 1999; Chung 2002; Kleinman et al. 1986). Distresses of physical health are likely to exacerbate the Chinese client's mental health condition.

Provider education. General practitioners are the gatekeepers to specialists and other medical services. To enhance practitioners' capacity to detect mental health problems early and to ensure adequate service provision, education and training are necessary to improve practitioners' skills and knowledge in identifying and treating mental health problems commonly seen in general practice settings. In addition, providers should learn how to communicate with patients about using culturally appropriate and familiar wordings, describe the biopsychosocial basis for mental illness, and discuss possible treatment plans.

Workforce development. Increasing the representation of bilingual and bicultural staff is critical in addressing the service utilization issue. Efforts should be made to attract and recruit bilingual and bicultural individuals to disciplines that are related to mental health service, such as nursing, medicine, psychology, and social work. Moreover, interpreter services should be made accessible at practices where bilingual service is not available. Providing culturally and linguistically appropriate services not only tackles the availability and accessibility issue, but also can address the negative effect of language discrimination on service utilization among Chinese immigrants.

Community outreach and education. Community outreach and education are necessary means to raise the awareness of mental health issues and to overcome the stereotypes of mental health problems among Chinese immigrants. Linguistically and culturally appropriate information related to mental health can be disseminated to members of the Chinese community through the use of educational brochures, mass media, health fairs, or community workshops.

Working with families. Family can exert a strong influence on a Chinese patient's healthcare decisions. Practitioners should not underestimate the pronounced influence of family on the lives of individuals with mental health problems (Kung, 2001; Uba, 1994), and should seek to understand the help-seeking patterns from the family-oriented perspective in addition to individual-focused assessment. Furthermore, practitioners should strive to engage the family members into help-seeking processes through harnessing the potential barriers resulting from a poor communication between providers and patient system. As each family has its idiosyncratic help-seeking and decision-making patterns; the trusting and respectful relationship among patient, family members and providers are likely to foster and maximize the treatment outcome.

Program development. Mental health needs and service use are influenced by socio-cultural determi-

nants. Policy and program makers should provide funding and technical support geared at encouraging the development of culturally appropriate and innovative mental health programs that maximize the service capacity in accordance with population needs. A pioneer program that integrates mental health and primary care in the Chinese community in New York City, NY has shown promising outcomes in delivering mental health services through culturally sensitive and creative approaches (Chen et al. 2005; Fang and Chen 2004). The program aims to enhance service access by providing mental health services in primary care; to enhancing the skills of general practitioners by training them to better identify and treat mental health problems commonly seen in general practice; and to raise community awareness by providing public education on mental health and mental illness. The program has been successfully operated for over a decade, proving that such a collaborate model can create new opportunities for improving access to mental health care, and ultimately enhance wellbeing for Chinese immigrants.

Premising that neither biomedicine nor the traditional healing paradigm can claim sole ownership of interpreting health and disease, and healing processes, integrative care that combines both traditional healing approaches and conventional medical treatments is increasingly available in Canada (Boon et al. 2004; Francoeur et al. 2006). Initial evaluation has shown that integrative care assists to increase patients' health status, including mental health functioning (e.g., Mulkins et al. 2003). The success of integrative care, although still preliminary, provides a new direction for effective models of mental health service provision. The philosophical underpinnings of integrative care are perhaps more congruent with beliefs of mental health among Chinese immigrants, and such a treatment approach has vast potential in effectively addressing patients' needs.

CONCLUSION

Due to cultural explanations of mental illness, stigma, discrimination, help-seeking preferences, and inadequate service, Chinese immigrants with mental health needs often become invisible to service providers. However, these issues are not unsolvable. Collective efforts can facilitate a responsive service environment that is accessible to, and culturally appropriate for, Chinese immigrants.

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FOOTNOTES

[1] Phase 1. Exclusive intrafamilial coping. At this stage, all possible remedial resources and means within the family are used by the family to influence the abnormal behaviour of the sick member to its limit of tolerance.

Phase 2. Inclusion of certain trusted outsiders in the intrafamilial attempt at coping, such as friends and elders in the community.

Phase 3. Consultation with outside helpers, such as herbalists, religious healers, physicians and finally a psychiatrist while keeping the patient at home.

Phase 4. Labelling of mental illness and seeking the psychiatric service first on an outpatient basis, and then hospitalization.

Phase 5. Scapegoating and rejection, while the sick family member is kept in a distant mental hospital.