DEFINING MENTAL ILLNESS AND ACCESSING MENTAL HEALTH SERVICES: PERSPECTIVES OF ASIAN CANADIANS

HAN Z. LI *and* ANNETTE J. BROWNE
University of Northern British Columbia

ABSTRACT

Asian Canadians consistently underutilize mainstream mental health services. This study investigates how the definition and meaning of mental illness relates to barriers Asian Canadians find in accessing mental health services. Personal interviews were conducted with 60 Asian Canadians in a northern community in the province of British Columbia. Content analyses revealed six themes that defined a mental health problem: (a) feeling a lack of purpose in life, (b) feeling lonely, (c) difficulties understanding and dealing with a new environment, (d) high anxiety levels, (e) descriptions of mental health problems as somatic illnesses, and (f) perceptions of mental illness as serious and potentially not treatable. It was also found that poor English language ability and a lack of understanding of mainstream culture were major barriers to accessing mental health facilities. Findings of this study provided valuable insights concerning Asian immigrants' hesitancy accessing and utilizing mainstream mental health facilities. The many poignant personal anecdotes illustrate that the migration and adaptation processes can be painful and full of anguish. Unless their experiences are better understood and accepted, many Asian Canadians will likely remain outside of the available mainstream mental health facilities.

INTRODUCTION AND LITERATURE REVIEW

It has been well documented that Asians who have immigrated to North America experience as many, and as serious, mental health problems as their Caucasian counterparts (Beiser et al., 1988; Christensen, 1986; Sue, Nakamura, Chung, & Yee-Bradbury, 1994). Yet Asian immigrants tend to underutilize mainstream mental health services (Beiser et al., 1988; Hu, Snowden, Jerrell, & Nguyen, 1991). Two main barriers have been identified as contributing factors: a lack of English-language proficiency and a tendency for health professionals to discount Asian culture (Naidoo, 1992; Beiser et al., 1988). In-depth knowledge of these barriers is lacking, however, as most research has been done through quantitative means. This study gathered qualitative and quantitative data from three groups of Asian Canadians regarding their understanding of mental health problems, the barriers they perceived in accessing mental health services, and other resources

This research was supported by a grant from Research and Graduate Studies, University of Northern British Columbia. This study is dedicated to the memory of Dr. David Fish, who inspired the research in the first place. An earlier version of this paper was presented at the *XXVI International Congress of Psychology* (August 16-21, 1996), Montreal, Canada.

they rely on for mental health needs. The presentation of these data is intended to help researchers and practitioners working in mental health to make sense of past findings and gain insight into the plight of Asian immigrants regarding mental health issues. Major literature in this area falls into three categories: (a) psychological well-being of Asian immigrants, (b) underutilization of existing services, and (c) barriers in accessing services.

Psychological Well-Being of Asian Immigrants

Asians who have immigrated to North American frequently present themselves as resilient, hardy people who are physically and mentally strong enough to survive the immigration process, to adjust to a foreign culture, and to prosper economically (Bagley, 1993; Sue & Morishima, 1982). Research has demonstrated, however, that the prevalence of mental health problems among this group is high (Sue et al., 1994). For example, in a study of 860 Asian Canadians in Toronto, it was found that the percentage of people who have mental health difficulties is as high as that of their Caucasian counterparts (Noh, Speechley, Kaspar, & Wu, 1992; Noh, Wu, Speechley, & Kaspar, 1992). Although many factors affect the psychological well-being of immigrants, the most significant seems to be the immigration process itself, which is uprooting and anxiety-ridden (Berry, Kim, Minde, & Mok, 1987; Dion, Dion, & Pak, 1992; Liebkind, 1996; Sam & Berry, 1995). Most Asian immigrants have limited English-language capacity, which hinders them from obtaining appropriate employment (Seward & McDade, 1988; Aycan & Berry, 1996). Consequently, unemployment and underemployment were found to have a severe negative impact on the psychological well-being of immigrants (Aycan & Berry, 1996; Beiser et al., 1988; Feather, 1990; Thomas, 1990). The usual symptoms are feelings of confinement, loneliness (Furnham & Bochner, 1990; Furuto, Biswas, Chung, Murase, & Ross-Sherif, 1992; Ng, 1993), restlessness, helplessness, and low self-esteem (Bagley, 1993; Berry, 1992; Dion & Dion, 1996; Dion, Dion, & Pak, 1992; Naidoo, 1992).

Underutilization of Mental Health Services among Asian Immigrants

Despite high rates of mental health problems, Asian Canadians underutilize mental health services (Beiser et al., 1988; Lai & Yue, 1990; Peters, 1988). A survey by the Greater Vancouver Mental Health Service Society (Peters, 1988) indicated that the utilization rate for South Asian and Chinese Canadians was significantly lower than that of Anglo-Canadians. Similar patterns were found between Asian Americans and Euro-Americans. Using a random sample of 161 Asian Americans and 1332 White Americans in the Los Angeles area, Zhang, Snowden, and Sue (1998) also found a significant difference between Asian and White Americans in utilization patterns of mental health facilities. Asian Americans were unwilling to use mental health services of any type and they tended to delay or avoid seeking professional mental health services (Flaskerud, 1986; Lee, 1986; Sue et al., 1994; Zhang et al., 1998). Further, when mental health services were accessed, Asian Americans were more likely to terminate treatment prematurely in comparison to other ethnic groups (O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue et al., 1994). Overall, findings in North America consistently reported that, in comparison to other ethnic groups and the Caucasian population, Asians under-

utilized mental health services, regardless of the type of service agency (e.g., acute inpatient care or community mental health centres) (Lee, 1986; Leong, 1994; Li, 1987; O'Sullivan et al., 1989; Zane, Hatanaka, Park, & Akutsu, 1994).

Barriers to Accessing Mental Health Services

Three main barriers to accessing mental health services have been identified. First, Asians who have immigrated to North America tend to associate mental illness with shame (Lai & Yue, 1990; Leong, 1994; Stefl & Prosperi, 1985; Sue et al., 1994). As a result, mental illness becomes a family secret (Lee, 1986). Due to the high level of stigmatization of the mentally ill and the necessity to conceal mental illness, mental health services are viewed as a last resort (Lai & Yue, 1990; Lee, 1986; Li, 1987; Leong, 1994).

Second, the vast majority of available mental health services are geared to the mainstream English-speaking population and are, therefore, inaccessible for clients of Asian backgrounds (Beiser et al., 1988; Nadoo, 1992; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Yeh, Eastman, & Cheung, 1994; Zane, Enomoto, & Chun, 1994; Zane et al., 1994). Many immigrants have limited English-language capacity and cannot describe their symptoms properly (Li, 1992; Ng, 1993; Stephenson, 1991). Asian immigrants' frequent lack of understanding of mainstream cultural norms and expectations (Ramakrishna & Weiss, 1992) further contributes to the difficulties which they experience when communicating with mainstream health professionals (Li, 1999a; Li, 1999b; Stephenson, 1991).

A third barrier is the racial discrimination which Asian immigrants experience when interacting with the mainstream service sector (Chan, 1987; Guzder, 1992; Naidoo, 1992; Goldberg & Hodes, 1992; Hine, Fenton, Hughes, & Velleman, 1995). Although much progress has been made since multicultural policies became enacted in 1971 (Berdichewsky, 1994; Breton, 1986), Canadians still feel more comfortable interacting with their own ethnic group members than with members of other groups (Angus Reid Group, 1991; Berry & Kalin, 1995). In 1991, the Angus Reid Group conducted a national survey of 2,500 Canadians, including 14 ethnic groups. It was found that Canadians feel less comfortable being among visible minorities, especially if the latter are not born in Canada (Esses & Gardner, 1996; Kalin, 1996). These results are mirrored by findings reported by Dion and Kawakami (1996), who surveyed 902 Canadians of various ethnicities in Toronto in 1992 and found that people of visible minorities perceived greater discrimination towards their group than whites. Davis and Gelsomino (1994) found discrimination to be an important factor influencing treatment results from the perspective of health professionals and clients. Not surprisingly, Sanders-Thompson (1996) contended that discrimination may impose measurable psychological distress on the discriminated. As a result, members of visible minorities who perceive themselves being the target of racial discrimination may be hesitant to seek the help of mainstream health professionals. Sanders-Thompson (1996) points out that, to gain the trust of minority clients and provide culturally appropriate services for them, mental health professionals need to be adequately trained.

Additional barriers discussed in the literature pertain to finances, transportation, and the lack of knowledge regarding the availability and location of services

(Steffl & Propseri, 1985). Disadvantaged by the various barriers described above, Asians in North America tend to rely on family members and informal sources of support when they experience mental health problems (Beiser et al., 1988; Flaskerud, 1986; Naidoo, 1992; Zane et al., 1994; Zhang et al., 1998).

To help Asian Canadians overcome these barriers, one must, first of all, understand how immigrants perceive and define being mentally ill. This study examines how mental health is described by three groups of Asian Canadians, and explores: (a) the barriers which they perceive to accessing mental health services compared to general health services, (b) their formal and informal sources of help, and (c) their past experiences interacting with health professionals.

METHODS

Procedures

Approval to conduct the study was granted by a university ethics review committee. Convenience sampling was used to recruit participants into the study since no accurate database was available from which to randomly select participants within the three ethnic groups.

Three female bilingual research assistants (RAs) who were active members of each ethnic group were hired to recruit participants and conduct face-to-face interviews. To achieve consistency among interviewers, the research assistants undertook two training sessions that included careful scrutinizing of each item in the Interview Guide so that a common understanding of the purpose of the question was achieved. This was followed by several hours of role playing where the RAs interviewed each other and worked through a variety of challenging interviewing scenarios.

Each RA recruited participants from various sources, including announcements at church gatherings, community meetings, and other gathering places. Once a participant was identified by an RA and verbal agreement to be in the study was obtained, an appointment was scheduled for a face-to-face interview. Snowball sampling (Polit & Hungler, 1999) was also used as community members who were interviewed identified further potential participants.

Informed consent was obtained from each participant prior to the interview. All interviews were conducted by the RAs in participants' homes. Interviews ranged in length from 15 to 40 minutes, with a mean duration of 21 minutes. All interviews were conducted within a three-month period in 1995.

Participants

Participants included members of three Asian Canadian groups: Chinese, Indian, and Filipino. Twenty members from each group were interviewed face-to-face ($N=60$). All participants were residents of a northern city located in a western province of Canada.

An approximately equal number of males and females from each group were interviewed. The age of participants was restricted to the 21 to 65 years old range. The mean age within each group ranged from 41 to 43 years old ($SD=12.2$). The

average length of residence in Canada among participants was 14 years (SD=12.93) for the Chinese group, 15 years (SD=7.84) for the Indian group, and 12 years (SD=8.60) for the Filipino group.

Of the Chinese participants, 85% chose to be interviewed in Chinese. Punjabi was used by 35% of the Indian participants. All of the Filipino participants responded in English by choice. The Filipino participants' preference for responding in English was reflected in their self-rated English fluency: 100% reported fluency in English, compared to 90% in the Indian group and 70% for the Chinese group. Educational levels were also highest among the Filipino participants, with 80% reporting completion of a college degree or higher, compared to 30% of the Indian and 30% of the Chinese participants. The majority of the respondents were employed outside the home (75%). However, the majority of the participants in the Chinese and Indian groups reported holding unskilled positions in Canada compared to higher-skilled positions in their countries of origin.

Translation

The method used for translation was a combination of back translation and bilingual technique recommended by Brislin (1980). Questions in the Interview Guide were developed in English and then translated into Chinese, Punjabi, and Filipino by the RAs and back-translated into English. For those who chose to use their native language in the interview, all answers were recorded in their native language and then translated into English for data analysis. To ensure that the meaning and spirit of the answers were reflected in the translation, the researchers and the research assistants went through each item with back translations.

Data Analysis

Descriptive statistics were used to analyze the quantitative data. Verbatim data were content analysed according to themes that emerged from open-ended responses to interview questions concerning participants' (N=60) definitions of mental health problems (Polit & Hungler, 1999). Content analysis was completed on all responses after labelling each answer according to ethnic group. Responses were reviewed and coded for recurring themes and patterns among participants' explanations of mental health problems. Inter-scorer reliability was between .89 and .92 (Pearson correlation) by scorers who separately coded responses according to the themes identified.

RESULTS

Definitions of "Having Mental Health Problems"

To obtain definitions of mental illness, participants were asked to describe their understanding of mental health problems. Content analysis of their responses revealed six common themes.

First, a large number of participants reported that a serious mental health problem was related to a person "feeling a lack of purpose in life." This theme was closely related to a feeling of "being lost all day," mainly due to a lack of

meaningful activities ("having nothing to do"). This theme was well illustrated by the following example:

> I have been in Canada for six years. I would like to work but I cannot find any suitable job. When I was in my home country, I worked as a university lecturer. All I do now is to stay at home and cook for my husband. I want to take care of my daughter's child, but she does not need me. Sometimes I feel that my life is wasted. I am only in my late 40s, you know. Not that old. Sometimes I feel so bored that I want to jump on the floor and scream.

A second theme was a prevailing feeling of loneliness. Some participants said that their loneliness was due to their "parents and the rest of the family being far away." "When you feel alone or feel a lack of support, you also feel insecure and have low self-esteem." Under such circumstances, a person "cannot feel happy." Some respondents also disclosed feeling a "lack of assurance" in a new environment.

> When I am restless, and this happens every day, my husband tells me to watch soap operas on tape; of course the tapes are in my native language. The more I watch that kind of movie, the more I want to go back to my home country. But my husband and daughter want to stay in Canada. My mother weeps every time I phone her. As my English is not very good, I feel like I am deaf, mute, and blind. I feel so handicapped that I want to die sometimes.

The third theme is having difficulties understanding and dealing with a new environment. Several participants revealed that they "have problems analysing situations and discerning their roles in them." One participant said, "when I don't understand what's around me, I can't make any right decisions." These difficulties result in their "having a hard time adjusting to life in Canada." One woman told the story of her humiliating experience working in McDonald's restaurant:

> As my English was poor, I washed dishes and helped in the kitchen. Most of the people working there were teenagers and I am in my early forties. At the beginning, they were very polite to me. After a while, they started to tease my English. They would giggle among themselves and that made me very angry. I told them to stop and they would not. One day I was so angry that I said the 'F' word to them. That is the only swear word I know in English. They told our boss and I was fired. With tears in my eyes I left. I wanted to explain to the manager but I couldn't find the right English words to do so. I believe this disturbing episode will haunt me as long as I live.

The fourth theme reflected the high anxiety levels experienced. Participants realized that, because they didn't have a full grasp of what is going on in their environment, they became "over-sensitive," "always thinking someone is out to get me." Some participants said that they were "overanxious in general, and had paranoid thoughts in particular." Anxious to reorganize their life in a new country, they tended to "have lots of things" on their minds, or to "be overly concerned," and "worry too much."

The fifth theme illustrated participants' tendency to describe mental health problems as somatic illnesses. Participants equated mental illness to being "not physically fit," or "not eating and sleeping properly." Mental health problems were also connected with pathology of the brain or other parts of body. For example, several participants related an "unhealthy brain" or "stammering while speaking" as mental illnesses.

The last theme emerging from the data was the perception of mental illness as very serious and untreatable. The symptoms attributed to mental illnesses were "having a major depression," "too much worry," and "a loss of appetite." They explained these problems as, "it's what you call crazy," or "getting insane." One participant said that she would cry for hours for no apparent reason. Although she could not find a professional job similar to what she used to do in her home country, she was satisfied with other aspects of her life. Her Canadian husband treated her very well, he had a good job, and they owned a nice house. She said that she had no reason to be sad, yet she felt sad all day long. Nevertheless, she would not consider herself to have any mental health problem. In her opinion, a mental health problem was something far more serious than what she experienced.

Another participant said that to have a mentally ill person in the family was akin to "having mad people at home—I would say that we should stay away from such people." Participants concluded "there is no cure for it [mental illness] whatsoever."

Perceived Barriers to Accessing Mental Health Services

Participants were asked to respond to the following question: "Suppose you needed to seek help with mental health issues, what kind of difficulties do you think you would face?" Respondents indicated "yes" or "no" to a wide range of barriers identified from the literature. Respondents were encouraged to offer their own responses in addition to those presented to them.

Poor English-language ability was reported as the most common barrier among the Chinese (70%) and Indian participants (60%), but was less common among the Filipino respondents (26%). The following example was given by a male participant:

> Once I went to the doctor when I had a severe stomach pain. After a brief check-up he presumed I had mental health problems. Though this was not the case I had to stay in the hospital for 5 days. The tests done on me were okay. The doctor didn't listen to me when I told him I did not have such a problem or maybe I did not explain myself clearly. I was given medicines to no effect and told to do exercises. The pain subsided after a long time.

The second most frequently reported difficulty was culturally-determined interpretation of mental illness that created barriers to seeking help. This opinion was unanimous among all three groups. This difficulty was illustrated by the following example:

> I have been with my boyfriend and his son of 14 for six years now and I have been living in fear of the monster boy. He would not let me watch a video in peace. He would either make big noises in the house to startle me or pretend to watch the movie with me, then complain how unworthy the movie is. When his father and I enjoy a moment together, he would pound on our bedroom door and ask us to open the door no matter how late it is. So we leave our bedroom door open all night. His father knows that the boy is psychologically disturbed but he would rather die than to admit it and take the boy to see a professional—that would be tantamount to a declaration of failure of himself as a human being. A month ago, the boy stole about eighty dollars from my purse. I coaxed the boy to admit it and give it back to me. I urged my boyfriend to take the boy to a psychologist. But he only said: "I don't believe in

> psychologists. I could never make an English-speaking psychologist understand my son's problem. It started eight years ago when his mother died in a car accident." I did not think there was anything I could do to change his mind. So I moved myself to the basement and have been there ever since.

To admit that a family member has a mental health problem may reflect badly on other family members, because the illness is sometimes considered to have a genetic aspect. In the above example, if the father allowed himself to think that his son may be psychologically troubled and admitted it to a health professional, he would be afraid that his own state of mind soon would be questioned. In the following example, a grown-up son would rather let his father's frequent and unreasonable tantrums destroy his marriage than accept that his father may be mentally ill and seek assistance. The daughter-in-law gave the following narration:

> My parents-in-law have been visiting us for the past year and I am on the edge of a mental and physical collapse. My mother-in-law is a fine woman. It is my father-in-law who frequently creates trouble for the whole family. In the middle of a family meal, he would rage over a dish or two and dump them to the sink, declaring that the dish is fit for pigs only. One evening, I cooked five of my favourite dishes for my daughter's birthday. In the middle of the meal, my father-in-law stormed at me with abusive words saying that I was a bad mother by letting my daughter do her homework after dinner. "She may fall asleep and never finish her homework," he shouted. "She has never skipped her school duties, not even once," I retorted. "How dare you to talk back to me. Who do you think you are? If my son had not got you to Canada, you would never be able to make it here yourself," he barked. I ran to my bedroom and closed my door and wept. Later, I reasoned with my husband that his father is perhaps suffering from some kind of mental illness. My husband said that he had known it for some time but would not do anything about it. "There is an old saying: family troubles stay in the house," my husband concluded reminiscently. I looked at the huge moon outside of our bedroom window and wondered if the moon knows this illogical old saying. I told my husband that he either went with the old saying or me, and he went to sleep in the basement.

The third most frequently reported barrier was "not knowing how to access mental health services." This was an issue among 60% of the Chinese, 50% of the Indian, and 10% of the Filipino participants.

Racial discrimination was also reported as a prominent barrier among 45% of the Indian, 35% of the Filipino, and 5% of the Chinese participants. Although all three groups disclosed that they experienced discrimination due to their race, Indian participants reported this problem more frequently than the other two groups. The Indian group also reported that health professionals did not treat them with respect during clinical interactions. Take the following as an example:

> I was brought to see a doctor. I was called into a waiting room. Shortly after, the nurse told me to go outside the doctor's room. No explanations were given by the nurse. I saw another person enter the doctor's room accompanied by some nurse. So I went home without talking to the doctor.

Another example was given by a female participant:

> Once I went to see a doctor. He did not listen to me when I was trying to tell him what was wrong with me. He ignored me. Instead he asked my husband (who is a Caucasian and English is his first language) questions as if he were the patient.

A related barrier, "health professionals do not like me," was perceived as a problem by 25% percent of Indian, 10% of Filipino, and none of the Chinese respondents. Lack of transportation was reported as a problem by 40% of the Indian, 20% of the Filipino and 5% of the Chinese participants.

To examine whether patterns of perceived barriers to accessing mental health services were different from or similar to those encountered when accessing general health services, participants were asked to respond to the same list of barriers, but in reference to general health services.

Although participants encountered much fewer barriers when accessing general health services compared to mental health services, language difficulties and cultural barriers still existed. A male participant reported a painful story stemming from his poor English ability:

> One morning when I was delivering the paper I picked up some fresh mushrooms. I had them for supper. I got very sick afterwards. My friend drove me to the emergency room. After a long wait, I was brought to a doctor. He asked me a few questions and I told him what had happened. He asked how I felt. I said that I was sleepy, very sleepy. He said "everybody is sleepy at 3:00 o'clock in the morning." I was discharged. No sooner did I step out of the hospital than I fainted. My friend brought me back to the emergency room and I was treated properly. I guess what I wanted to say to the doctor was that I felt like I was fainting or I was losing my consciousness. But I did not know those words in English. I just said "sleepy."

Perceived discrimination was reported less frequently (10%) when accessing general health services compared to accessing mental services (28%). Interestingly, while 40% of participants reported not knowing how to access mental health services, only 3.3% reported not knowing how to access general health care services. Overall, perceived barriers were much greater when accessing mental health services than when accessing general health services.

Due to the strong relationship between cultural barriers and access to mainstream health care services (Davis & Proctor, 1989; O'Sullivan et al., 1989; Sue et al., 1994; Zane et al., 1994), the final question asked in the interview was, "In your opinion, how well do health care providers know your culture?" Respondents were asked to rate their answers on a scale from zero (not at all) to five (very knowledgeable). The mean score for Chinese was 1.00 ($SD = .73$), 1.30 ($SD = 1.08$) for Indian, and 2.35 ($SD = 1.46$) for Filipino respondents.

It seems that the length of stay in Canada did not have an impact on the number of perceived barriers to mental health services. A Pearson correlation indicated no significant relationship between the number of years residing in Canada and the number of barriers reported by the participants ($r = .04$, $N = 60$, $p > .05$). Those who resided in Canada for a shorter period of time did not report more barriers than those who resided in Canada for a longer period of time.

Formal and Informal Sources of Support for Mental Health Issues

The final section of the questionnaire asked participants where they might turn for support or help if they needed it. The vast majority of participants in all three groups said they would seek help from family members. Friends were reported as

another important source of help for all but Chinese respondents. While Indian respondents identified traditional medicine healers as a source of support, participants from other ethnic groups did not.

Respondents were also asked what type of mental health professional they had seen in the past year. Only 5% of the Indian and Filipino participants had sought the help of a counsellor, and no respondents sought the services of a psychologist. However, when asked whether they would be open to professional help, should it be available and accessible, 90% of the Indian, 65% of the Filipino, and 50% of the Chinese participants responded in the affirmative.

DISCUSSION

Results of this study indicate that Asian Canadians do have mental health problems, and they usually seek the help of family members and friends instead of health professionals. Although many of them are willing to consider the option of health professionals, there will be a long way to go before they actually do so. Formidable barriers exist both intrinsic to their own cultural norms (e.g., family troubles stay inside the house) and to the reality that Canada's mental health services are geared to the mainstream English-speaking population. Below is a detailed analysis of the findings of this study.

Themes of Mental Health Problems

The six themes which emerged from the data regarding the definition of mental health problems present a compelling picture of the mental health status of Asian Canadians. The first theme was "feeling of a lack of purpose in life," which reflects the existential anxiety of having nothing to do since many immigrants are either underemployed or unemployed (Aycan & Berry, 1996; Li, 1992). When immigrants arrive in a new country, credentials from their home country are usually not well accepted (Aycan & Berry, 1996; Li, 1992) and many professionals end up working as labourers. A loss of identity leads to psychological imbalance, which in turn leads to a loss of purpose in life.

The second theme reported was loneliness, which develops when immigrants are faced with the many difficulties in a new environment, and are unable to receive the same level of support from family and friends as they would have in their home country. With the loss of their old densely-knit social network and the lack of a newly established network, how can they not feel lonely?

The third theme related to the difficulties which participants experienced adjusting to life in their new home country. Most immigrants come to the West looking for a better life. Unfortunately, they find themselves unable to speak the language well, and feel like misfits within a new culture that is drastically different from that of their home. Therefore, adaptation and adjustment become a daily struggle.

The fourth theme focused on the participants' high anxiety levels. This finding was consistent with previous research addressing acculturation stress (e.g., Berry, 1992; Dion & Dion, 1996; Dion et al., 1992; Liebkind, 1996) or culture shock (Fernando, 1991; Furnham & Bochner, 1990). Functioning in a second language

and a foreign culture naturally results in high anxiety levels (Gudykunst & Kim, 1997; Gudykunst & Ting-Toomey, 1988). Edward Hall (1976) pointed out that anxiety results from newcomers' lack of awareness of the hidden dimensions of a foreign culture—the unwritten rules which are shared by every native but are invisible to foreigners. It is not surprising that immigrants feel highly stressed as they deal with the unfamiliar and the unknown.

The fifth theme arising from our data was the tendency to describe mental health problems as somatic illnesses, which is consistent with previous findings (Beiser et al., 1988; Lai & Yue, 1990; Leong, 1986; Lin, 1985, Zhang et al., 1998). Despite various explanations of somatization among Asians, based on in-depth interviews with participants in this study, we argue that it is related to the sixth and final theme—their tendency to describe the mentally ill as "mad" people, as suffering from a state of ill health which is beyond help. For example, an Asian person would tend to be shocked by a Caucasian colleague's declaration that "I am depressed" when he is just a little "down." Somatic illnesses, on the other hand, are treatable, curable, and, most importantly, are something that one should hardly be ashamed of. This feeling of shame is well reflected in a quote by an Indian participant, "If my neighbour knows that my husband has a mental health problem, he will not let his daughter marry my son."

Barriers to Accessing Mental Health Services

Participants in this study identified insurmountable barriers that limited their access to, and utilization of, mental health services. The two most serious difficulties were related to language and cultural barriers which they encountered when interacting with the dominant health care system (Li, 1999a, Li 1999b). These findings are consistent with other studies which assert that cultural differences create the strongest barriers to accessing mental health services (Kagawa-Singer & Chung, 1994; Lai & Yue, 1990; Leong, 1994; Naidoo, 1992; Zane et al., 1994).

The third most commonly reported barrier was "not knowing how" to access mental health services. An obvious implication of this finding is that mental health agencies should increase public awareness of how to access services, especially for ethnic groups that experience language and cultural barriers. This finding is particularly relevant for the groups included in this study, since the majority of respondents reported that they would seek services if these were made more accessible.

Racial discrimination was the fourth most frequently reported barrier. While this was a significant barrier experienced by both Indian and Filipino participants, it was reported infrequently by Chinese respondents. The barriers created by racial discrimination have been noted in other studies involving ethnic minorities' access to mental health services (Davis & Gelsomino, 1994; Gong-Guy, 1987; Krieger, Rowley, & Allen, 1993; Sanders-Thompson, 1996). Furthermore, Krieger, Rowley, and Allen (1993) and Sanders-Thompson (1996) have found that perceived discrimination also creates mental health problems. These findings point to the need for the mental health service sector to address issues of discrimination at the

micro (individual) and macro (system) levels if access for ethnic minorities is to be improved.

Inter-group comparisons in the present study reveal that Filipino participants reported the least barriers to mental health services. This finding corresponds well with findings from other studies which document fewer difficulties in accessing mental health care facilities among Filipinos than among other Asian groups (Leong, 1994; Tracey, Leong, & Glidden, 1986). Leong (1994) suggests that there may be less shame or stigmatization associated with seeking mental health care services among Filipinos than there is among other Asian American groups.

The differences in barriers found between ethnic groups in the present study point to the importance of conducting research on specific Asian groups instead of combining different groups into one data set (Leong, 1994). Leong, for example, warned that the latter method, while being expedient, may mask important between-group differences.

The Eurocentric orientation of the majority of Canada's mental health care services was reflected in respondents' perceptions that health care providers were not familiar with their cultures. This finding points to the need for increased cultural awareness and sensitivity training for health care providers (Li, 1999a). Similar recommendations have been proposed by other researchers who advocate for an expanded range of culturally-based mental health services for Asian immigrants (Furuto et al., 1992; Kagawa-Singer & Chung, 1994; Zane et al., 1994).

Given the barriers to accessing and utilizing mental health services, it was not surprising that a high proportion of respondents reported that they would use family and friends for support and assistance. This finding has been supported in other studies, which note that Asian immigrants tend to look first to their families for help, often to avoid the stigmatization of seeking professional services (Beiser et al., 1988; Naidoo, 1992; Leong, 1986; Lin, Tardiff, Donetz, & Goresky, 1978; Sue, 1993; Tracey et al., 1986; Webster & Fretz, 1978). It is, therefore, important for mental health professionals to make a concerted effort to respect clients' informal networks of support (Cook, 1994). Further research is needed to examine this potentially powerful means of addressing mental health care needs and usage patterns in specific ethnic groups.

Although significant barriers were reported in relation to mental health services, fewer barriers were reported in regard to general health services. Similar findings were also reported by Matuk (1996), who concluded that immigrants faced difficult challenges when attempting to access mental health care services but less so when accessing general health care services. In light of these findings, it may be advantageous to offer mental health and general health services at the same location. For example, situating mental health services in locations that offer primary care or community health services may improve access (Beiser, Shore, Peters, & Tatum, 1985; O'Sullivan et al., 1989; Sue, 1993; Zane et al., 1994).

Based upon the findings of this study, we make the following recommendations to improve the situation for Asian Canadians:

(1) There is a need for more bilingual and bi-cultural mental health professionals in different sectors, such as community mental health centres and major hospitals.

(2) There is a need to inform new immigrants of Canada's mental health care system through existing social services (such as English as a Second Language (ESL) classes and multicultural service societies). This information should be available in a brochure and translated into different languages.

(3) There is a need to teach mental health professionals the basics of cultural norms and values regarding mental health issues of various minority groups. Health professionals who have minority members as their clients need to educate themselves through appropriate training courses, self-study, or professional development activities, or by obtaining information and educational materials from the Canadian Mental Health Association.

CONCLUSION

Through face-to-face interviews, this study has provided valuable insight concerning Asian immigrants' hesitancy in accessing and utilizing mainstream mental health facilities. The many poignant personal anecdotes illustrate the pain and anguish inherent in the migration and adaptation processes which Asian Canadians experience. Unless these experiences are better understood and accepted, many Asian Canadians will likely remain outside of the available mainstream mental health facilities.

RÉSUMÉ

Les Canadiens et Canadiennes d'origine asiatique n'utilisent pas assez souvent les services en santé mentale. Cette étude examine comment la définition et le sens du terme «santé mentale» ont un rapport avec les barrières auxquelles font face les Canadiens et Canadiennes d'origine asiatique lorsqu'ils ont besoin d'assistance en santé mentale. Des entrevues personnelles ont été conduites avec 60 Canadiens et Canadiennes d'origine asiatique dans une communauté située au Nord de la Colombie-Britannique. Les analyses de ces entrevues révèlent 6 thèmes. Le terme «problème de santé mentale» est perçu comme: (a) une absence de but dans la vie, (b) un sentiment de solitude, (c) des difficultés à comprendre et à faire face efficacément à un nouvel environnement et (d) un haut niveau d'inquiétude. Une analyse de contenu des données démontre que les Canadiens et Canadiennes d'origine asiatique ont tendance à: (e) décrire les problèmes de santé mentale comme des maladies somatiques et (f) perçevoir la maladie mentale comme étant très grave et incurable. Les barrières les plus reconnues quant à l'accès aux services de santé mentale sont la connaissance médiocre de l'anglais et les malentendus culturels. Tous les thèmes et barrières reconnues sont soutenus par des anecdotes personnelles. Les processus de migration et d'adaptation peuvent être pénibles et remplis d'angoisse. Tant que leurs experiences ne seront pas mieux comprises et acceptées, plusieurs Canadiens et Canadiennes d'origine asiatique vont probablement continuer d'ignorer les services de santé mentale disponibles.

REFERENCES

Angus Reid Group. (1991). *Multiculturalism and Canadians: Attitude study 1991 (National Survey Report)*. Ottawa: Multiculturalism and Citizenship Canada.

Aycan, Z., & Berry, J.W. (1996). Impact of employment-related experiences on immigrants' psychological well-being and adaptation to Canada. *Canadian Journal of Behavioural Science, 28*, 240-251.

Bagley, C.R. (1993). Mental health and social adjustment of elderly Chinese immigrants in Canada. *Canada's Mental Health*, Fall, 1993.

Berdichewsky, B. (1994). *Racism, ethnicity and multiculturalism*. Vancouver: Future Publications.

Beiser, M., Wood, M., Barwick, C., Berry, J.W., deCosta, G., Milne, W., Fantino, A.M., Ganesan, S., Lee, C., Tousignant, M., Naidoo, J., Prince, R., & Vela, E. (1988). *After the door has been opened: Mental health issues affecting immigrants and refugees in Canada*. Ottawa: Ministries of Multiculturalism and Citizenship, and Health and Welfare.

Beiser, M., Shore, J.H., Peters, R., & Tatum, E. (1985). Does community care for the mentally ill make a difference? A tale of two cities. *American Journal of Psychiatry, 142* (9), 1047-1052.

Berry, J.W., & Kalin, R. (1995). Multiculturalism and ethnic attitudes in Canada: An overview of the 1991 national survey. *Canadian Journal of Behavioral Science, 27*, 301-320.

Berry, J.W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review*, 21, 362-384.

Berry, J.W. (1992). Acculturation and adaptation in a new society. *International Migration Review, 30*, 69-85.

Breton, R. (1986). Multiculturalism and Canadian: Nation-building. In A. Cairns & C. Williams (Eds.), *The politics of gender, ethnicity and language in Canada* (pp. 27-66). Toronto: University of Toronto Press.

Brislin, R. (1980). Analysis of oral and written materials. In H.C. Triandis & J.W. Berry (Eds.), *Handbook of cross-cultural psychology: Methodology* (pp. 389-444). Boston: Allyn and Bacon, Inc.

Chan, K.B. (1987). Perceived racial discrimination and response: An analysis of perceptions of Chinese and Indo-Chinese community leaders. *Canadian Ethnic Studies, 19* (3), 126-147.

Christensen, C.P. (1986). Perceived problems and health-seeking preferences of Chinese in Montreal. In K.V. Ujimoto & J. Naidoo (Eds.), *Asian Canadians: Asian Canadian Symposium VI* (pp. 68-83). Winnipeg: University of Manitoba Press.

Cook, P. (1994). Chronic illness beliefs and the role of social networks among Chinese, Indians, and Angloceltic Canadians. *Journal of Cross-Cultural Psychology, 25*, 452-465.

Davis, L.E., & Gelsomino, J. (1994). An assessment of practitioner cross-racial treatment experiences. *Social Work, 39*(1), 116-122.

Davis, L.E., & Proctor, E.K. (1989). *Race, gender and class: Guidelines for practice with individuals, families, and groups*. Englewood Cliffs, NJ: Prentice Hall.

Dion, K.L., & Dion, K.K. (1996). Chinese adaptation to foreign cultures. In M.H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 457-478). Hong Kong: Oxford University Press.

Dion, K.L., Dion, K.K., & Pak, A. (1992). Personality-based hardiness as a buffer for discrimination-related stress in members of Toronto's Chinese community. *Canadian Journal of Behavioural Science, 24*, 517-536.

Dion, K.L., & Kawakami, K. (1996). Ethnicity and perceived discrimination in Toronto: Another look at the personal/group discrimination discrepancy. *Canadian Journal of Behavioral Science, 28*, 203-213.

Esses, V.M., & Gardner, R.C. (1996). Multiculturalism in Canada: Context and current status. *Canadian Journal of Behavioral Science, 28*, 145-152.

Fernando, S. (1991). *Mental health, race and culture*. Hampshire, UK: MacMillan.

Feather, N.T. (1990). *The psychological impact of unemployment*. London: Springer-Verlag.

Flaskerud, J.H. (1986). The effects of culture-compatible intervention on utilization of mental health services by minority clients. *Community Mental Health Journal, 22*, 127-141.

Furnham, A., & Bochner, S. (1990). *Culture shock: Psychological reactions to unfamiliar environments*. London: Routledge.

Furuto, S.M., Biswas, R., Chung, D.K., Murase, K., & Ross-Sherif, F. (Eds.). (1992). *Social work practice with Asian Americans*. Newbury Park, CA: Sage.

Goldberg, D., & Hodes, M. (1992). The poison of racism and the self-poisoning of adolescents. *Journal of Family Therapy, 14*, 51-67.

Gong-Guy, E. (1987). *The California Southeast Asian mental health needs assessment*. Oakland, CA: Asian Community Mental Health Services.

Gudykunst, W.B., & Kim, Y.Y. (1997). *Communicating with strangers: An approach to intercultural communication*. New York: McGraw-Hill.

Gudykunst, W.B., & Ting-Toomey, S. (1988). *Culture and interpersonal communication*. Newbury Park, CA: Sage Publications.

Hall, E.T. (1976). *Beyond culture*. New York: Anchor Books, Doubleday.

Gazder, J. (1992). South Asian women: Psychological issues related to assimilation. In R. Ghosh & R. Kanungo (Eds.), *South Asian Canadians: Current issues in the politics of culture* (pp. 105-117). Montreal: Shastri Indo-Canadian Institute.

Hine, C.E., Fenton, A.O., Hughes, A.O., & Velleman, G. (1995). Coronary heart disease and physical activity in South Asian women: Local context and challenges. *Health Education Journal, 54*, 431-443.

Hu, T., Snowden, L., Jerrell, J., & Nguyen, T.D. (1991). Ethnic populations in public health: Services choice and level of use. *American Journal of Public Health, 81*(11), 1429-1434.

Kalin, R. (1996). Ethnic attitudes as a function of ethnic presence. *Canadian Journal of Behavioral Science, 28*, 171-179.

Kagawa-Singer, M., & Chung, R.C. (1994). A paradigm for culturally based care in ethnic minority populations. *Journal of Community Psychology, 22*, 192-208.

Krieger, N., Rowley, D.L., & Allen, H.A. (1993). Racism, sexism, and social class: Implications for studies of health, disease, and well-being. *American Journal of Preventive Medicine, 9* (Suppl. 6), 82-122.

Lai, M.C., & Yue, K.M. (1990). The Chinese. In N. Waxler-Morrison, J.M. Anderson, & E. Richardson (Eds.), *Cross-cultural caring: A handbook for health professionals in western Canada* (pp. 68-90). Vancouver: University of British Columbia Press.

Lee, R.N.F. (1986). The Chinese perception of mental illness in the Canadian mosaic. *Canada's Mental Health, 34*(4), 2-4.

Li, K.C. (Feb., 1987). *The Chinese perspective towards mental illness and its implication in treatment*. Paper presented at Shaughness Hospital, Vancouver, B.C., Canada.

Leong, F.T.L. (1994). Asian-Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii. *Journal of Community Psychology, 22*, 82-96.

Leong, F.T.L. (1986). Counselling and psychotherapy with Asian Americans: Review of the literature. *Journal of Counselling Psychology, 33*, 196-206.

Li, H.Z. (1992). *Chinese health priority survey in the Province of British Columbia*. Victoria: British Columbia Ministry of Health.

Li, H.Z. (1999a). Communicating information in conversations: A cross-cultural comparison. *International Journal of Intercultural Relations, 23*, 387-409.

Li, H.Z. (1999b). Grounding and information communication in intra- and inter-cultural dyadic discourse. *Discourse Processes, 28*(3), 195-215.

Lichkind, K. (1996). Acculturation and stress: Vietnamese refugees in Finland. *Journal of Cross-Cultural Psychology, 27*, 161-180.

Lin, T.Y. (1985). Mental disorders and psychiatry in Chinese culture: Characteristic features and major issues. In W.S. Tseng & D.Y.H. Wu (Eds.), *Chinese culture and mental health: An overview*. New York: Academic Press.

Lin, T., Tardiff, K., Donetz, G., & Goresky, W. (1978). Ethnicity and patterns of help-seeking. *Culture, Medicine and Psychiatry, 2*, 3-13.

Matuk, L. (1996). Health status of newcomers. *Canadian Journal of Public Health, 87*(1), 52-55.

Naidoo, J.C. (1992). The mental health of visible ethnic minorities in Canada. *Psychology and Developing Societies, 4*(2), 165-187.

Ng, K.Y. (1993). Volunteer work and settlement: A study of Chinese immigrant women. *Canada Journal of Community Mental Health, 12*(2), 31-44.

Noh, S., Speechely, M., Kaspar, V., & Wu, Z. (1992). Depression in Korean immigrants in Canada: Method of the study and prevalence. *Journal of Nervous and Mental Disease, 180*, 573-577.

Noh, S., Wu, A., Speechely, M., & Kaspar, V. (1992). Depression in Korean immigrants in Canada: II. Effects of gender, work, and marriage. *Journal of Nervous and Mental Disease, 180*, 578-582.

O'Sullivan, M.J., Peterson, P.D., Cox, G.B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17*, 17-30.

Peters, R. (Feb., 1988). *The interagency mental health council's committee on multiculturalism and mental health: Progress update*. Vancouver: Greater Vancouver Mental Health Services Society.

Polit, D.F., & Hungler, B.P. (1999). *Nursing research: Methods, appraisal and utilization* (6th ed.). Philadelphia: J.B Lippincott.

Ramakrishna, J. & Weiss, M. (1992). Cross-cultural medicine: A decade later. *Western Journal of Medicine, 157*, 265-270.

Sam, D.L., & Berry, J.W. (1995). Acculturative stress among young immigrants in Norway. *Scandinavian Journal of Psychology, 36*, 10-24.

Sanders-Thompson, V.L. (1996). Perceived experiences of racism as stressful life events. *Community Mental Health Journal, 32*(3), 223-233.

Seward S., & McDade K. (1988). *Immigrant women in Canada: A policy perspective*. Ottawa: Canadian Advisory Council on the Status of Women.

Stefl, M.E., & Prosperi, D.C. (1985). Barriers to mental health service utilization. *Community Mental Health Journal, 21*(3), 167-178.

Stephenson, P.H. (1991). *The Victoria multicultural research project*. Victoria: British Columbia Ministry of Health.

Sue, S. (1993). The changing Asian American population: Mental health policy. In LEAP . Asian Pacific American Public Policy Institute & UCLA Asian American Studies Center (Eds.), *The State of Asian Pacific America* (pp. 79-94). Los Angeles: LEAP Asian American Public Policy Institute & UCLA Asian American Studies Center.

Sue, S., Fujino, D.C., Hu, L. Takeuchi, D.T., & Zane, N.W.S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533-540.

Sue, S., & Morishima, J. (1982). *The mental health of Asian Americans*. San Francisco: Jossey-Bass.

Sue, S., Nakamura, C.Y., Chung, R.C.Y., & Yee-Bradbury, C., (1994). Mental health research on Asian Americans. *Journal of Community Psychology, 22*, 61-67.

Thomas, D. (1990). Immigrant integration in Canada. In S. Globerman (Ed.), *The immigration dilemma* (pp. 211-260). Vancouver: The Fraser Institute.

Tracey, T.J., Leong, F.T.L., & Glidden, C. (1986). Help-seeking and problem perception among Asian Americans. *Journal of Counselling Psychology, 33*, 331-336.

Yeh, M., Eastman, K., & Cheung, M.K. (1994). Children and adolescents in community health centres: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22*, 153-163.

Webster, D.W., & Fretz, B.R. (1978). Asian-American, black, and white college students' preferences for helping services. *Journal of Counselling Psychology, 25*, 124-130.

Zane, N., Enomoto, K., & Chun, C. (1994). Treatment outcomes of Asian- and White-American clients in outpatient therapy. *Journal of Community Psychology, 22*, 177-191.

Zane, N., Hatanaka, H., Park, S., & Akutsu, P. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian-American clients. *Journal of Community Psychology, 22*, 68-81.

Zhang, A.Y., Snowden, L.R., Sue, S. (1998). Differences between Asian and white Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology, 26*, 317-326.