A Sociocultural Perspective of Mental Health Service Use by Chinese Immigrants

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Abstract

The underutilization of mental health services by Chinese immigrants is a critical health and equality issue. This article reviews sociocultural factors that may contribute to low mental health service use across individual, family, cultural and system domains, and discusses ways to improve the responsiveness of social work practice to the mental health needs of Chinese immigrants. Based on a critical analysis of literature, the article concludes that Chinese immigrants may be deterred from seeking help for their mental health problems because of the cultural explanation of mental illness, shame and stigma, psychosomatic symptom presentation, help-seeking preference, effect of discrimination, lack of recognition by general practitioners, a lack of accessibility to linguistically and culturally appropriate mental health services, and the use of complementary and alternative medicine (CAM). Specific social work practice considerations for assessing and treating Chinese immigrants are discussed. Social workers are encouraged to understand the connections among mind, body, and spirit, and to demonstrate sensitivity to clients’ symptom presentations. We also encourage social workers to learn about the cultural and linguistic meanings associated with mental health and mental illness, and to assume a proactive role in inquiring about CAM use with a non-judgmental attitude. Social workers should strive to work with family members, become involved in community outreach and education, and consider culturally-appropriate program models.

Keywords: Mental health • mental illness • Chinese • immigrants • service utilization

According to Census 2006, Canada is the home of 667,405 immigrants of Chinese origin (Statistics Canada, 2009) and the Chinese continue to be the largest immigrant group (Milan & Martel, 2008; Statistics Canada, 2008). Immigrants often experience elevated levels of psychological distress in the period that follows immigration (Beiser & 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 & Ponizovsky, 1999; Tang, Oatley & Toner, 2007). Paradoxically, studies conducted in North America have repeatedly reported that Chinese immigrants underuse mental health services (Abe-Kim et al., 2007; Chen & Kazanjian, 2002; Chen, Kazanjian, Wong & Goldner, 2010; Kung, 2003; Matsuoka, Breaux & Ryujin, 1997; Sue & Sue, 1999; Tiwari & Wang, 2008). By the time Chinese immigrants finally receive formal mental health treatment, they tend to present more severe symptoms compared to non-immigrant users, are harder to treat, and frequently require lengthy

To address disparities in mental health service use among Chinese immigrants, it is necessary to first understand factors that may contribute to their service use pattern. From a sociocultural perspective, this article reviews causes of mental health service underuse among Chinese immigrants and discusses practice implications.

Factors explaining service underuse among Chinese immigrants 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 use. The perceived causes of mental illness include 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, Kwong, Lee & Chung, 2002; Lin & Lin, 1981). As implicated in the religious or cosmological perspective, mental illness has also been perceived as representing the wrath of supernatural spirits (Gaw, 1993; Koss-Chioino, 2000; Kramer et al., 2002) or ancestors, (Barnes, 1998; Lin & Lin, 1981) induced by clients or other family members. One Toronto study reported that Chinese immigrant women who subscribe to supernatural beliefs tend to hold a negative attitude toward seeking professional help (Fung & Wong, 2007). Traditional medical theory, which considers all illnesses, both physiological and mental, to be imbalances of yin and yang (Chung, 2002; Ergil, Kramer & Ng, 2002; Ma, 1999), also plays an important role. Psychosocial factors, such as major life events and difficulties, are also considered to contribute to the onset of mental illness (Kramer et al., 2002; Lin & Lin, 1981; Tang et al., 2007). Lastly, genetic transmission and the inheritance of the consequences of familial misconduct may also be considered causes of mental illness (Lin & Lin, 1981). Each component described above is weighted differently, depending upon the individual and the context.

The effect of stigma among the Chinese is often reflected in a low rate of mental health service use, excessive concern about confidentiality, reluctance to use insurance coverage, and absolute refusal to seek professional help in the face of obvious psychiatric symptoms.

Shame and stigma attached to mental illness may also prevent Chinese immigrants and their families from seeking mental health services (Chung, 2002; Gaw, 1993; Sadavoy, Meier & Ong, 2004). Although stigma is a well-recognized issue across cultures, it may have more severe and decisive consequences among the Chinese (Sue & Sue, 1987). The effect of stigma among the Chinese is often reflected in a low rate of mental health service use, excessive concern about confidentiality, reluctance to use insurance coverage, and absolute refusal to seek professional help in the face of obvious psychiatric symptoms (Gaw, 1993).

Literature suggests that within the collective and family-centered cultural orientation in Chinese society, an individual’s mental illness taints family, and naming and shaming extends to ancestors (Kramer et al., 2002; Lin, 1981). Furthermore, seeking mental health services is not only considered shameful for the individual, but also for his family members, ancestors and offspring (Gaw, 1993; Leong...
Fear of “losing face” and being derided is common among Chinese families with mentally ill members. This 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 & Cheung, 1999; Uba, 1994). Often, Chinese clients express their psychological problems in a somatic form (Kung & Lu, 2008), which can explain why somatization and neurasthenia are commonly observed in Chinese communities. Somatization is “the presentation of personal and interpersonal distress in an idiom of physical complaints together with a coping pattern of medical help-seeking” (Kleinman, Anderson, Finkler, Frankenberg & Young, 1986, p. 51). Consistent with the Chinese cultural context, somatization suppresses 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 a desire to avoid the strong stigma attached to mental illness. Additionally, somatization is consistent with the perceived legitimacy of seeking help for bodily complaints rather than psychological issues (Kleinman, 1981).

Somatization also contributes to the popular use of neurasthenia. Originating in the U.S. in the 1860s, neurasthenia was introduced into China in the early 1900s and has been widely accepted and recognized in Chinese communities (Flaskerud, 2007; Kleinman et al., 1986; Lee, 1998). Neurasthenia is a complaint of increased physical or mental fatigue that 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, with psychological issues being 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).

The Chinese collective, family-oriented culture also influences Chinese immigrants’ help-seeking preferences. The family, rather than the individual with mental illness, often makes the treatment decisions (Lin & Cheung, 1999; Lin & Lin, 1981). The formal institution is frequently the last resort for people with severe mental illness such as 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 & 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 did seek help, family and friends appeared to be the major source (20%). Moreover, among respondents who had a diagnosable mental disorder, only 15% had ever used mental health services, a rate much lower than the national figure of 25% as reported in the National Comorbidity Study (Kessler et al., 1994).

Attention should also be given to the mental health needs and help-seeking behaviours of Chinese immigrant women. Socialized with and subjugated into a gendered family role, Chinese women, fearful of being judged as incompetent or inadequate, tend to be reluctant to discuss family or personal concerns with outsiders (Chiu, 2004). Although Asian immigrant women report experiencing more psychological stress than men (Chung & Bemak, 2002), and play a key in helping other family members adjust (Wong, 1998), many neglect their own
mental health needs and suffer quietly. The perceived precedence of family concerns over individual issues (O’Mahony & Donnelly, 2007) may restrict immigrant women’s efforts in accessing mental health services in the community.

Racism and discrimination are facets of social context that are always present in the lives of visible minorities and can influence mental health service use by Chinese immigrants. The perception of being treated unfairly or with disrespect due to one’s race or ethnic background can foster the development of mistrust of service providers and subsequent reduced service use among minority populations (Spencer & Chen, 2004; van Ryn & Fu, 2003). Spencer and Chen (2004) have found that discrimination is associated with greater use of informal services among Chinese Americans, and is also associated with their more frequent seeking of assistance from friends or relatives. Moreover, discrimination that occurs as a result of speaking a different language or having an accent significantly contributes to the types of services people use. Chinese Americans who 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 treatment.

Under-recognition by general practitioners also contributes to underuse of mental health services. Somatization, or focusing on somatic symptoms of mental health issues, naturally leads Chinese clients to consult their general practitioners, rather than seeking help from mental health professionals (Hsu & Folstein, 1997; Kung & Lu, 2008). Chen and Kazanjian (2009) note that many Chinese immigrants tend to seek medical services from general practitioners who share their language and culture, but these practitioners often fail to recognize and address their clients’ mental health issues. Moreover, the provider stigma (i.e. physicians’ fear of embarrassing their clients) further exacerbates negative feelings and inaccurate myths about mental illnesses, and delays proper referrals and treatment for clients who are in need (Chung, 2002).

Even when individuals, family members or general practitioners recognize the need for mental health services, their efforts to access mental health services are often hampered by the lack of linguistically and culturally appropriate mental health services available (Fung & Wong, 2007; Sadavoy et al., 2004). Research has shown that providing well-trained and culturally matched providers promotes the acceptance of mental health treatment among Chinese immigrants and helps ensure equal access and treatment opportunities (Lin, 1994). However, many mainstream institutions are not equipped with either ethnic-specific professionals or competent interpreters. Long waiting lists also erect a prominent barrier to availability (Sadavoy et al., 2004).

Lastly, the use of complementary and alternative medicine (CAM) also influences access to conventional mental health services. Literature suggests that along with traditional Chinese health beliefs, indigenous medical practices exert an important influence on the manifestation of symptoms and health behaviours among Chinese clients (Barnes, 1998; Kleinman et al., 1975, 1978). First, Chinese clients may rely on traditional Chinese...
medical practitioners, such as herbalists or acupuncturists, for relief from emotional difficulties (Barnes, 1998; Lin & Cheung, 1999). In addition, as noted earlier, the folk concept that supernatural forces and ancestral deeds cause mental illness is widely accepted in Chinese society. Folk healers such as shamans, physiognomers, geomancers, bonesetters, and fortune-tellers are common components of the way the Chinese manage daily stresses and treat illnesses (Gaw, 1993). In Kung’s study (2003), 8% of Chinese respondents with emotional problems had sought help from herbalists, acupuncturists, religious leaders or fortune-tellers.

**Implications**

The above discussion illuminates the definition of mental illness, subsequent help seeking, alternative coping strategies and the interrelationships shaped by cultural beliefs and norms in Chinese communities. As is true for other ethnic groups, multidimensional and complex reasons contribute to mental health service use among Chinese immigrants. Several practice and program considerations to address this underuse of mental health services are discussed below.

**Assessment and treatment considerations**

Social workers’ understanding of the interconnections among mind, body, and spirit is essential if they are to provide more relevant, effective and efficient services. When assessing and treating Chinese immigrants, social workers should demonstrate sensitivity to clients’ symptom presentation, as well as to their perspective about their discomfort, which they may not view as mental disorders. Social workers should strive to understand the cultural and linguistic meanings associated with mental health and mental illness. Such knowledge will facilitate their initial working strategies in communicating with clients on mental health-related concerns.

Unexplained somatic symptoms among Chinese clients may be a manifestation of mental health issues (Chung, 2002; Kleinman et al., 1986; Lin & Cheung, 1999). Since clients may present their concerns primarily within the somatoform spectrum and thus mask the underlying mental health problems, social workers should recognize such patterns and assist clients in making connections between their physical and mental health. Furthermore, social workers should learn how to communicate with clients using culturally appropriate and familiar wordings, describe the biopsychosocial basis for mental illness, and discuss possible treatment plans.

Despite the common use of complementary and alternative medicine (CAM) among Chinese clients with mental health needs (Fang & Schinke, 2007), social workers may not be aware of such practices (Burge & Albright, 2002). Clients may feel uncomfortable disclosing their CAM use due to the fear of being criticized or scorned by their service providers (VandeCreek, Rogers & Lester, 1999). Indeed, these indigenous approaches to mental health and mental illness are often overlooked and devalued by the empirically driven medical model of mental health, and remain misunderstood and understudied. Neither biomedicine nor the traditional healing paradigm can claim sole
ownership of interpretation regarding health, disease and the healing process (Cook, Becvar & Pontious, 2000). Social workers should assume a more proactive role in inquiring about CAM use during their assessment with a non-judgmental attitude. Such practice can help service providers understand such use, evaluate potential impacts and further coordinate care.

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 and gender-sensitive 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. Involving the community in the development, design, and delivery of the programs holds promise for reaching immigrant women (Hyman & Guruge, 2002).

Program development

Policy makers and program designers should provide funding and technical support geared towards encouraging the development of culturally appropriate and innovative mental health programs that maximize service capacity in accordance with population needs. A pioneer program that integrates mental health and primary care services in the Chinese community in New York City has shown promising outcomes in delivering mental health services through culturally sensitive and creative approaches (Chen, Kramer, Chen, Chen & Chung, 2005; Chen, Kramer & Chen, 2003; Fang & Chen, 2004). Aiming to increase clients’ access to mental health services, the program: a) enhances the skills of general practitioners by training them to better identify and treat mental health problems commonly seen in general practice; b) installs a mental health team consisting of psychiatrists, psychiatric social workers, and case workers within a primary care setting; and c) raises community awareness by providing public education on mental health and mental illness. The program has successfully operated for more than a decade, proving that such a collaborative model can create new opportunities for improving access to mental health care, and ultimately enhance the well-being of Chinese immigrants.
Conclusion
Due to cultural explanations of mental illness, stigma, discrimination, help-seeking preferences, and inadequate service provision, Chinese immigrants with mental health needs often become invisible to service providers and are less likely to access mental health services. Culturally sensitive assessment and treatment, community outreach, and innovative program development can facilitate a responsive service environment that is accessible to, and culturally appropriate for, Chinese immigrants.

References


**Biographical notes**

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