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Original paper

Regional differences among ethnic Chinese on level of acculturation to Canadian culture and perceived barriers to mental health help seeking

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Abstract. ***Background*** *Ethnic Chinese are the largest immigrant population within Canada, yet they consistently under-utilize mental health services. Acculturation is considered an important factor in accessing services within the target country; however it is unclear if there are differences among ethnic Chinese in terms of accessing services and their level of acculturation.* ***Methods*** *A self-report questionnaire was administered to a convenience sample of ethnic Chinese at two sites in Metro-Vancouver (community & hospital) in order to examine the level of comfort and embarrassment, as well as perceived attitudinal and structural barriers in accessing mental health services.* ***Results*** *Higher levels of embarrassment in mental health seeking were found in subjects from the community, and from Mainland China. Higher attitudinal barriers were found in whereas greater structural barriers were found in the community sample. Subjects with more than 12 years of education or who used English in everyday life identified more with Canadian culture.* ***Conclusion*** *Traditional cultural values appear to be salient in accessing mental health services among ethnic Chinese. This has relevance with respect to improving access and utilization of mental health resources by ethnic Chinese in order to provide screening for common mental health disorders such as depression.*

Keywords: acculturation, mental health, multicultural health, barriers, Chinese.

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INTRODUCTION

Across Canada, mental disorders remain a sensitive topic of discussion due to their close association with stigma, which makes effective utilization of mental health services challenging. This is particularly salient among immigrant populations, including the Chinese, which tend to underutilize available mental health services compared to the general population (Ali *et al*, 2004; Chen & Kazanjian, 2005; Fenta *et al*, 2006; Laroche, 2000; Reitz, 1995; Sadavoy *et al*, 2004; Shin, 2002; Whitley *et al*, 2006). Indeed, Chinese immigrants are the second largest ethnic group among immigrants to Canada, and the largest in British Columbia (BC), accounting for 40% of its visible minority (BC Stats, 2006; Statistics Canada, 2006; Statistics Canada, 2010).

Previous research has identified several factors associated with the decreasing utilization of mental health treatment pathways among Chinese immigrants such as demographic characteristics, lack of language skills, inadequate health coverage, stigma and shame (Chen *et al*, 2008; Chung, 2010; Ho *et al*, 2008). When mental health services are accessed it appears to be correlated with general medical consultations. Therefore, Chinese immigrants are less likely to consult health professionals for any, not just mental health problems compared to the general population (Chen *et al*, 2009).

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Embarrassment and stigma are salient Chinese cultural characteristics that reflect the broader concept of interdependence which in turn are associated with decreased help seeking behaviour (Chung, 2010; Tabora & Flaskerud, 1997). Identification with Chinese or Western culture is determined by a person's level of acculturation. Acculturation has been found to predict help seeking attitudes and behaviours for mental health issues among Asians, with Asians who are more acculturated to the host culture having more favourable attitudes towards seeking treatment (Zhang & Dixon, 2003). In Chinese immigrants the level of acculturation to the host culture was associated with higher utilization of mental health services, while higher identification with Chinese heritage was found to predict reluctance in seeking treatment (Chan *et al*, 2001; Hsu & Alden, 2008; Kung, 2004; Tabora & Flaskerud, 1997). Therefore, acculturation may be an important variable in determining the extent to which Chinese immigrants are willing to seek help for mental health difficulties.

Although acculturation among ethnic Chinese has been widely investigated in the social sciences, a large proportion of studies have used 2nd or 3rd generation individuals as study samples (Abe-Kim *et al*, 2002; Chung, 2010; Miller *et al*, 2011; Oei & Raylu, 2009; Ting & Hwang, 2009; Yamashiro & Matsuoka, 1997; Ying, 1990; Ying & Miller, 1992). Furthermore, although the association between acculturation and mental health treatment seeking is a topic of interest in the field of social and cultural psychology, the large-scale national health surveys done in the field of psychiatry and public health tend to under estimate the importance of this variable. Therefore, little attempt has been made to include a validated acculturation measure in data collection of clinical surveys. Consequently it is important to examine this variable in not only 1st generation subjects, but also clinical and community samples. Therefore the aim of this study was to examine the level of comfort, embarrassment, perceived attitudinal and structural barriers in accessing mental health services with respect to: (1) regional differences among ethnic Chinese from three main subgroups (Mainland China, Hong Kong, and Taiwan), (2) whether there were differences between relevant demographic variables, and level of acculturation to mainstream Canadian culture or ethnic Chinese and perceived barriers to accessing mental health services.

METHOD This was a naturalistic research design incorporating a structured questionnaire. The questionnaire was based upon items from the National Co-morbidity Survey (NCS), Ontario Health Survey, Mental Health Supplement (OHS), and the Vancouver Index of Acculturation (VIA) (Kessler *et al*, 2004; Ryder *et al*, 2000). It consisted of six main parts:

1. Demographics (12 questions)
2. Willingness to seek help for mental health issue (1 question; Yes-No)
3. Past use of mental health services (1 question; Yes-No)

4a. Level of embarrassment in seeking professional help for mental health issue (5 questions)
4b. Level of comfort in discussing mental health issues (5 questions) (4-point Likert scale; not at all to very)

5a. Perceived structural barriers in accessing mental health services (7 questions)
5b. Perceived attitudinal barriers in accessing mental health services (6 questions) (5-point Likert scale; strongly disagree to strongly agree)

6a. Acculturation to Canadian culture (10 questions)
6b. Acculturation to Chinese culture (10 questions) (9-point Likert scale, strongly disagree to strongly agree).

The questionnaire was translated from English to Chinese (Mandarin and Cantonese) by two of the authors (both fluent in English, Mandarin, and Cantonese languages) and then back translated to ensure continuity and validity of items. This allowed subjects to respond in the language that they were most proficient and comfortable to communicate in (**Table 1**).

Table 1 Sample questions from scales

Willingness to seek help for mental health issue
• People differ a lot in their feelings about professional help for emotional problems. If you had a serious emotional problem, would you go for professional help?
Past use of mental health services
• Have you ever sought professional help for problems with your emotions, nerves or your use of alcohol or drugs?
Level of Embarrassment
• Would you be embarrassed if the following people knew you were getting professional help for an emotional problem?
• Family
• Distant Relatives
• Close Friends
• Acquaintances that you rarely spoke to
• Strangers that you just met
Level of Comfort
• How comfortable would you be talking about your personal problems with the following people?
• General Practitioner
• Psychiatrist / Clinical Psychologist
• Counsellor / Social Worker
• Priest (or other religious representative)
• Friends / Family
Perceived structural barriers in accessing mental health services
• My health insurance might not or would not cover the treatment.
• The treatment would take too much time or would be inconvenient.
• The treatment was too expensive
• I did not know how to access the services or treatments.
Perceived attitudinal barriers in accessing mental health services
• I wanted to solve the problem on my own.
• I felt a loss of face having to be treated or helped for this type of problem.
• The treatment was too expensive.
• I did not feel comfortable enough to talk about my private thoughts with the professionals
Acculturation to Canadian and Chinese culture
• I often participate in my heritage cultural traditions.
• I often participate in mainstream Canadian cultural traditions.
• I would be willing to marry a person from my heritage culture.
• I would be willing to marry a Canadian person.
• I enjoy social activities with people from the same heritage culture as myself.
• I enjoy social activities with typical Canadian people.
• I am comfortable working with people of the same heritage culture as myself.
• I am comfortable working with typical Canadian people.

After institutional ethical approval was obtained, the questionnaire was administered to a convenience sample of 149 ethnic Chinese subjects between November 1, 2011 to February 28, 2012 at two sites: (1) Vancouver General Hospital Cross Cultural Psychiatry Clinic (VGH) and S.U.C.C.E.S.S., a large cultural, vocational, settlement, and social service organization serving the Asian community in Metro-Vancouver for over 30 years. The questionnaire was completed in a private waiting office at both locations. A total of 127 (85%) questionnaires were returned after informed consent to participate in the study was obtained from the subject. The study was conducted in accordance with the Declaration of Helsinki and its subsequent revisions.

Analysis

Descriptive statistics were be used to describe the basic features of the cohort. Next, non-parametric (Mann-Whitney U-test, Kruskall-Wallis test, Chi-square) statistics were used to compare demographic to outcome measures (comfort, embarrassment, attitudinal & structural barriers, Chinese acculturation, Canadian acculturation). Statistical significance was set at $p<0.05$, two-tailed. Data were entered and analyzed using SPSS version 19.0 (IBM Inc., USA).

RESULTS

Demographics

As shown in **Table 2**, the majority of subjects were recruited through S.U.C.C.E.S.S. (86%), were from mainland China (50%), female (74%), partnered (77%), had more than 12 years of education (65%), spoke Mandarin (62%), and were willing to seek treatment for a mental health issue (90%). Subjects had been in Canada for a mean of 10.2 (SD 9.5) years, had a mean age of 43.7 (SD 11.7) years, and lived with a median of 4 other family members. Twenty-six percent of subjects reported using some form of mental health service in the past, and this was statistically significant between sites (VGH 67% vs. SUCCESS 18%, $X^2=21.6$, $p<.01$).

Table 2 Cohort Characteristics (N, %)

Site	**(N, %)**	**Uses English**	**(N, %)**
VGH	21 (17)	Yes	35 (28)
SUCCESS	106 (83)	No	92 (72)
Place of Birth		**Yrs of Education**	
China	63 (50)	≤12 years	37 (29)
Hong Kong	41 (32)	>12 years	83 (65)
Taiwan	17 (13)	Not Stated	7 (6)
Other	6 (5)		
Gender		**Seek Help**	
Female	94 (74)	Yes	114 (90)
Male	33 (26)	No	13 (10)
Marital Status			
Single	29 (23)		
Partner	98 (77)		
Past Drug Issue		**Mother Tongue**	
No	93 (73)	Mandarin	80 (62)
Yes	33 (26)	Cantonese	45 (34)
Not stated	1 (1)	English	1 (2)
		Korean	1 (2)

Embarrassment, Comfort, Attitudinal, & Structural Barriers

Level of embarrassment in seeking professional help for a mental health issue, comfort in talking about mental health issues, as well as attitudinal and structural barriers in accessing mental health services were compared against demographic variables (**Table 3**). Higher levels of embarrassment were found at SUCCESS ($\bar{x}=14.0$) compared to VGH ($\bar{x}=11.8$). Mainland Chinese scored higher on embarrassment ($\bar{x}=13.7$) compared to subjects from Hong Kong ($\bar{x}=11.2$), but not Taiwan ($\bar{x}=12.9$) or other countries ($\bar{x}=11.5$). Perceived attitudinal barriers were higher in men ($\bar{x}=19.7$) compared to women ($\bar{x}=17.2$). Perceived structural barriers were higher at SUCCESS ($\bar{x}=19.3$) compared to VGH ($\bar{x}=16.5$) and for those with more than 12 years of education ($\bar{x}=19.5$ vs. 17.9). Subjects with more than 12 years of education ($\bar{x}=59.1$ & 57.1) identified more with Chinese and Canadian culture compared to those with less than 12 years of education ($\bar{x}=55.3$ & 53.0). Subjects who used English in

daily life ($\bar{x}$=62.2) also identified more with Canadian culture compared to those that did not ($\bar{x}$ =53.8).

Table 3 Mean (SD) Outcome Scores by Demographic Variable

	Comfort Level	Embarrassment Level	Attitudinal Barriers	Structural Barriers	Acculturation Chinese	Acculturation Canadian
Site						
VGH	14.9 (3.4)	14.0 (3.5)[1]	19.2 (6.2)	16.5 (4.3)[2]	54.3 (12.2)	56.7 (12.9)
SUCCESS	15.9 (2.8)	11.8 (3.9)	17.6 (5.2)	19.3 (4.3)	58.9 (10.7)	56.0 (10.3)
Gender						
Men	15.8 (2.9)	12.7 (4.2)	19.7 (6.0)[3]	18.7 (4.2)	58.4 (11.4)	56.3 (11.1)
Women	15.7 (3.0)	12.0 (3.9)	17.2 (5.1)	18.9 (4.5)	58.1 (10.9)	56.1 (10.7)
Marital Status						
Single	15.5 (3.7)	12.1 (4.9)	18.3 (6.8)	19.0 (5.0)	57.6 (14.0)	60.3 (11.6)[4]
Partner	15.8 (2.7)	12.2 (3.7)	17.7 (4.9)	18.8 (4.2)	58.3 (10.0)	54.9 (10.3)
Education						
<12 years	9.8 (3.4)	12.4 (4.6)	17.2 (5.8)	17.9 (4.5)[5]	55.3 (9.5)[6]	53.0 (9.0)[7]
>12 years	8.9 (2.7)	13.0 (3.7)	18.3 (5.3)	19.5 (4.4)	59.1 (11.8)	57.1 (11.4)
Place of Birth						
China	15.2 (3.3)	13.7 (4.2) [8]	17.1 (4.4)	18.7 (4.4)	59.4 (10.7)	55.5 (9.4)
Hong Kong	16.2 (2.7)	11.2 (3.5)	18.8 (6.7)	18.9 (4.0)	57.3 (12.0)	57.4 (10.7)
Taiwan	14.8 (2.8)	12.9 (4.0)	19.0 (5.2)	20.0 (4.6)	57.1 (11.3)	57.1 (13.6)
Other	16.1 (2.4)	11.5 (3.9)	16.5 (4.6)	17.1 (7.1)	54.8 (7.4)	51.8 (15.8)
Income						
<40k	15.7 (2.9)	12.4 (4.0)	18.1 (5.1)	19.3 (4.3)	57.2 (11.4)	56.8 (9.1)
>40k	15.3(3.1)	12.1 (3.9)	17.9 (5.8)	18.4 (4.7)	59.5 (10.4)	55.5 (13.4)
Uses English						
No	15.9 (2.8)	12.0 (3.9)	17.8 (5.5)	18.6 (4.6)	58.4 (10.1)	53.8 (9.6)[9]
Yes	15.3 (3.2)	12.8 (4.2)	18.1 (5.2)	19.5 (3.7)	57.6 (13.4)	62.2 (11.2)

(1) z=-2.31, p=.021; (2) z=-2.58, p=.010; (3) z=-1.99, p=.046; (4) z=-2.56, p=.010; (5) z=-2.08, p=.037; (6) z=-2.15, p=.032; (7) z= -2.19, p=.028; (8) x^2=14.9, P=.001; (9) Z=-3.82, P=.000

DISCUSSION The present study examined the relationship between acculturation (Chinese and Canadian), and level of comfort and embarrassment, with perceived structural and attitudinal barriers in accessing mental health services in a sample of ethnic Chinese. Higher levels of embarrassment were found in subjects who were recruited from mainland China with respect to talking about mental health issues. This is consistent with research that has shown that mainland Chinese patients feel shame and embarrassment about mental illness (Hsiao *et al*, 2006). SUCCESS is a local Chinese community agency which provides cultural, vocational, settlement and social services to new ethnic Chinese immigrants to British Columbia. In contrast, VGH provides specific ethno-cultural mental health services. Therefore subjects seen at SUCCESS may not be aware of the scope of services available within the local and may be more embarrassed about discussing mental health issues compared to those attending VGH, who have been seen by their General Practitioner for their mental health issues and referred to VGH to see a psychiatrist. Furthermore a greater proportion of subjects recruited into the study were from mainland China (50%). Although Mainland China and Hong Kong are seen as collective cultures (Goffman, 1955), each area has its own unique political and economic system (Hofstede, 1980). It may be that due to Hong Kong's historical exposure to Western culture (i.e. a British Colony until 1997) that they have incorporated Western mental health treatment therapies, including cognitive and behavioural therapies that are more "talk" oriented compared to mainland Chinese, and thus may feel more open when discussing mental health issues.

Perceived attitudinal barriers were found to be higher in subjects who were male which may be partially attributed comfort in and reluctance to self-disclose. These factors affect how men perceive possible treatments for mental disorders. For example, Chinese prefer medication over psychotherapy in treatment partly because of the belief that body and mind are connected (Chan *et al*, 2001), and

therefore simply treating the mind (psychotherapy) is neither sufficient nor effective (Tabora & Flaskerud, 1997). Furthermore, men tend to see having a mental illness as a loss of face (Kung, 2004). Therefore, mental health issues may be culturally relevant and resistant to change in Chinese culture.

Perceived structural barriers were higher in subjects from SUCCESS or subjects who had more than 12 years of education. SUCCESS deals more with cultural, social and settlement services rather than mental health issues, consequently clients at SUCCESS may be unfamiliar with what mainstream mental health treatment resources are available and how to access them. Furthermore, the number of mainland Chinese immigrants to Canada and British Columbia with post-secondary education continues to increase yearly (BC Stats, 2006; Statistics Canada, 2005). Many immigrants face challenges when entering a new country and culture including a reduction in income and social status and an inability to find suitable employment for a number of years until they are established. In the present study, subjects' level of education may be acting as a surrogate for both objective and perceived social status. In a survey of Asian-Americans Gong showed that individuals with higher perceived social status had higher rates of mental disorders, and were less likely to access mental health services (Gong *et al*, 2012).

With respect to site, a large proportion of the sample was recruited from SUCCESS which focuses primarily on cultural and social services, and therefore subjects from SUCCESS may have not yet sought help for mental health issues. In contrast subjects at VGH were attending an outpatient clinic for a known mental health issues. Indeed, 67% of VGH subjects compared to 18% of SUCCESS subjects had sought help for a past mental health issue. This suggests that familiarity and experience with existing mental health services may be important in how Chinese patients perceive structural barriers to accessing services. Therefore it is important to incorporate early screening and detection of mental health disorders in community-based agencies for appropriate treatment and improved clinical outcome.

The present study elucidated regional differences among ethnic Chinese, and the influence of acculturation to Chinese or Canadian culture on perceived barriers (attitudinal and structural). The results raise important questions. First, perceived barriers (attitudinal and structural) may not be influenced by level of acculturation to Chinese or Canadian culture. Future studies should examine the contribution of other cultural variables outside of acculturation as predictors of perceived barriers.

Second, the finding that males have more negative attitudes than females for perceived attitudinal barriers, suggests that mental health services should be made attractive option for Chinese men. For example, mental health outreach campaigns could try to convince men with mental health issues that seeking help from a gambling counselor can be just as supportive and comfortable as seeking help from a close friend or family.

There are several limitations to this study that should be noted. Subjects consisted of a convenience sample of individuals who consented to participate in the study. Therefore we were unable to determine the specific mental health issues, if any, that these subjects may have suffered from and how that may contribute to perceptions of attitudinal and structural barriers. Second, the sample was relatively homogenous with respect to acculturation scores on both Canadian and Chinese culture measures which may have made differentiating between the two and their impact on perceived barriers difficult. Finally, we used self-report questionnaires in which subjects were required to complete the questionnaire as honestly as possible. Although subjects completed the questionnaire in the presence of one of the researchers, it is not known if subjects had recall bias or deliberate omissions when they completed it.

CONCLUSION The findings of the study provide a snapshot of how a cohort ethnic Chinese sub-groups views barriers using mental health services in Metro Vancouver. The study showed that there were differences with respect to perceived attitudinal and structural barriers. With a trend for more ethnic Chinese immigrating to Canada there could be a greater increase in accessing mental health services. It is therefore crucial that hospital and community-based agencies and service providers strive to educate immigrated Chinese Canadians not only with respect to accessing and

utilizing mental health resources, but also in avoiding stigma and feelings of shame and embarrassment that may be associated with seeking help.

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