Depression through Chinese eyes: a window into public mental health in multicultural Australia (PhD Thesis Summary)

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Depression through Chinese eyes: a window into public mental health in multicultural Australia

從華裔人士對抑鬱症的理解

透視澳洲多元文化心理衛生政策

Bibiana Chan 陳智穎

Summary

2008

For all my informants who honestly and courageously shared their thoughts and experiences with me.

獻給所有為這項研究提供寶貴資料的參加者

To my LORD who gives me HOPE.

致掌管萬有並賜我希望的主

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Abstract

Under-utilisation of mental health services is widespread globally and within Australia, especially among culturally and linguistically diverse (CALD) communities. Improving service access is a priority, as is the need to deliver culturally competent services to the CALD communities. Having migrated to Australia in waves for approximately 150 years from China and South East Asia for various social, political and economic reasons, the Chinese population in Sydney is now the fastest growing non-English speaking ethnic group. There is a need to better understand the impact of culture on the emotional experiences of these Chinese in Australia. How do Chinese make sense of their depressive episodes?

To address this question, this study explored the ways participants reach out for medical and/or non-medical help. Lay concepts of illness underpin these decisions and were thus unveiled. Mixed-method research design provided the opportunity to bring together multiple vantage points of investigation: population mental health, transcultural psychiatry and medical anthropology. A study combining quantitative survey and qualitative focus groups was undertaken in metropolitan Sydney. Narratives on symptoms, explanatory models and help-seeking strategies were articulated by focus group informants. Surveys covered demographics, symptom-recognition, previous depressive experiences and professional help sought. Depression measurement tools were cross-culturally validated. Self-ratings of ethnic identities and the Suinn-Lew Self-Identity Acculturation Scale were used to quantify Chinese participants' acculturation level. This allowed comparisons between 'low-acculturated' Chinese', 'highly-acculturated' Chinese and Australians.

Survey results showed comparable levels of symptom-recognition in all subgroups. Focus group discussions provided rich data on informants' help-seeking strategies. Highly acculturated Chinese closely resembled the Australians in many study variables, yet qualitative data suggested cultural gaps beyond language barriers in influencing service use. Participants believed that trustful relationships could work as the bridge to link services with those in need. The implications for Australia's mental health policy include recognising the importance of rapport-building and the existence of cultural gaps. The study indicated professionals can benefit from acquiring information about the mental health beliefs both of individual clients and the wider ethnic communities in which they belong, and respecting the cultural differences between helper and helped as the first step towards cultural competency.

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正心、修身、齊家、治國、平天下

One must cleanse one's heart, build one's character, manage one's family affairs, govern one's country, so that one rules the world.

Confucius, *Greater Learning*

1. A glance at mental health issues

Mental health issues have attracted much attention globally. The World Health Organization claims that by 2020 depressive disorders will rank second in terms of Disability Adjusted Life Years (WHO 2002) behind Ischemic Heart Disease (IHD). Mathers and Loncar (2006) projecting ahead a further decade using WHO 2002 data (2004) have suggested that by 2030 Unipolar Depression will continue to rank second with HIV/AIDS at the top and IHD dropping to third place. There is thus an urgent need to shift the focus from intervention to prevention. The first step is to set up public education campaigns promoting mental health literacy[1]. Western developed countries, including the United States and Britain, have made great efforts to promote awareness of depressive disorders. Hong Kong, which in the past has reported a low prevalence of lifetime depression, has also launched a public campaign (the Joyful Mental Health Foundation 2004) to promote mental health literacy.

In Australia today mental health issues are acute. It is a problem that the Australian Government can no longer ignore. The then Prime Minister and the State Premiers[2] met at the Council of Australian Governments (COAG) in February 2006 to discuss the pressing need for more effective programs to combat widespread depression and other mental health disorders (Australian Broadcast Corporation, ABC 2006). The New South Wales Premier, acknowledging the shortage of psychiatrists in the public health system (ABC 2006), has expressed the need to 'think outside the square'. To achieve these goals mental health experts must (a) address the gaps in the existing services and (b) explore ways of utilising the existing mental health workforce more efficiently.

[1] Mental health literacy includes the ability to recognise specific disorders, knowing how to seek mental health information, knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (Jorm, Korten, Jacomb et al. 1997:182)

[2] The Prime Minister: John Howard and premiers of NSW: Morris Iemma; South Australia: Mike Rann; Queensland: Peter Beattie; Tasmania: Paul Lennon; Victoria: Steve Bracks; WA: John Carpenter.

Research funds allocated to Australia's non-English speaking population groups are a mere 1.5 % of the total for mental health. In effect there are few existing studies that address the specific issues surrounding mental disorders in people from culturally and linguistically diverse (CALD) backgrounds. Despite the national initiative called 'beyondblue[3]', launched in 2000 to raise public awareness of clinical depression (beyondblue, 2004), there are lingering doubts as to whether the Australian Government is committed to tackling this serious problem head-on.

When interviewing psychiatrists in Hong Kong, Miller (2006) observed an interesting phenomenon in the case of the psychiatrist who said: 'If I make a diagnosis of postnatal depression, the family will think the mother is mad… [so] I'll say "Have you heard of postnatal depression? In TCM (Traditional Chinese Medicine) this is how your condition is viewed," and encourage them to see a herbalist' (Miller 2006: 463). One of the major reasons Chinese psychiatrists embrace both Western and Chinese medical concepts is that it gives them the chance to focus on the physical root of the illness thus lessening the chance of stigma. Green and colleagues note in an earlier report (Green, Brandby, Chan et al., 2002) that even Chinese women who speak English fluently and have integrated well into the mainstream culture prefer to seek help from health professionals with similar cultural backgrounds, hoping that the latter will have a better understanding of the cultural nuances of their emotional distress. Culture thus seems to play a vital role in determining where help is sought, especially when the problems are perceived to be more than purely physical. When a person moves from his/her heritage culture to live in another culture, the impact of culture on that person becomes more evident.

Three important issues emerged from my literature review: (1) there is increasing concern about mental illness among the Chinese in Asia as well as in Western countries; (2) there is evidence to suggest there are some advantages in adopting both Western and Traditional Chinese medical concepts in the management of emotional distress; and (3) culture and help-seeking for mental ill-health are clearly associated. With these issues in mind, I proceed to explore how Chinese people living in Sydney, who are straddling the Australian (predominately Anglo-Celtic) and Chinese cultures (a) view their emotional distress /bouts of depression, and (b) employ help-seeking strategies. Even more importantly, I examine the concepts

[3] 'beyondblue' was established by former Victorian Premier Jeff Kennett in 2000, He was appointed by the then Federal Minister for Health to head a $5 million National Centre for 'Depression'.

underlying these phenomena in order to elucidate the complex relationship between culture and illness. These findings will hopefully shed light on the kind of mental health services that are culturally competent for the growing Chinese community in Australia.

2. Chinese migrants in Australia

As highlighted earlier, understanding the influence of culture on help-seeking behaviours for mental ill-health, in this case by following how migrants from a non-Western culture residing in a predominantly Western setting reach out for help for emotional distress, has the potential to assist mental health professionals to strengthen service delivery. Chinese living in Sydney represent Australia's fastest-growing non-English speaking community. There are over half a million Chinese living in Australia representing approximately 3% of the Australian population (Australia Bureau of Statistics ABS, 2002a), with Chinese ranking fifth after English, Irish, Italians and Germans among the major ethnic groups. A recent census (ABS 2002) established that 400,000 people (i.e. 2.1% of the Australian population) are Chinese-speaking.

Waves of Chinese migration span the period from the Gold Rush in the 1850s to the new millennium. The children of those who came to Australia as indentured labourers would now extend to the third and fourth generations. However, non-white migration was not always welcomed in Australia. It was only in 1966, when the Immigration Minister (Hubert Opperman) undertook to review the immigration policy, that non-Europeans who possessed qualifications useful to Australia were accepted, thus marking the watershed of the White Australia Policy. Successive governments gradually removed race as a factor in Australia's immigration policies from 1973. Since then, Australia has seen a sizeable influx of non-white Asian migrants including refugees from Vietnam.

After the Tiananmen Square Student Movement in China in 1989, the Hawke Labour Government granted 25,000 Chinese students Australian residence. The political upheaval and anti-Chinese riots in Indonesia in the 1990s triggered another wave of Chinese migration. In the decade prior to Hong Kong's return to Chinese rule in 1997, many skilled and more affluent Hong Kong Chinese migrated to Australia, establishing residence in the country's major cities. In 1996, tension between China and Taiwan also saw many professionals migrate from Taiwan. Since the beginning of the new

millennium and the escalation of globalisation, international migration has become increasingly active; it is no longer surprising to find Chinese born in different parts of the world migrating to Sydney, for example. The Chinese community is the fastest growing non-English speaking ethnic group in Australia and there are well-established Chinese communities enhancing the maintenance of their 'cultural heritage'.

3. Meaning of emotional distress

An important pre-requisite to seeking professional help for emotional distress is recognising the need to do so. Do the Chinese explain their emotional distress as normal life responses or as something deviant that warrants medical intervention as in the case of being clinically depressed? Simon and colleagues' cross-national study (Simon et al., 2002) indicates that higher thresholds for reaching the state of clinical depression were observed in centres with a low prevalence of clinical depression, in the city of Shanghai, China, for example. All societies have their own indigenous labels for a condition which in the West is called clinical depression. One classic example is the popularity of the term ***s**hen-**j**ing-**s**huai-**r**uo* or SJSR to the Chinese, borrowed from the concept of neurasthenia and indigenised within Traditional Chinese Medicine. SJSR translates as weakness of the body channels carrying *qi* or vital energy. Historically, neurasthenia allowed a culturally sanctioned and socially acceptable mantle to be developed that was distinct from psychiatric labelling and its consequences. The non-stigmatizing nature of SJSR is the major reason for its popularity among the Chinese. A further 'sanitizing' element lies in the fact that there are specific Chinese herbal remedies that relieve SJSR. In addition, the concept of SJSR blends well with the indigenous belief in Chinese Cosmology, which emphasises the importance of establishing the '*yin/yang'* balance and restoring the functions of the 'five organs' (See Chan and Parker , 2004 for more detail). Thus, in a broad sense, each culture also provides its unique indigenous means of healing which is culturally sanctioned within the local context. It may be that many people are not conscious of this socio-moral aspect of emotions: the suppression and expression of emotions serve the important function of regulating social harmony within the larger community.

From the Western biomedical perspective, the American Psychiatric Association Diagnostic Statistical Manual Fourth Edition DSM_IV (American Psychiatric Association, 1994) in Axis 1 sets the diagnostic criteria for 'Clinical Depression' as including:

> Five (or more) of the following symptoms which have been present during the same two-week period most of the day, nearly every day, and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.
>
> *(1) depressed mood,*
> *(2) markedly diminished interest or pleasure in all, or almost all, activities,*
> *(3) significant weight loss when not dieting or weight gain,*
> *(4) insomnia or hypersomnia,*
> *(5) psychomotor agitation or retardation,*
> *(6) fatigue or loss of energy,*
> *(7) feelings of worthlessness or excessive/ inappropriate guilt,*
> *(8) diminished ability to think or concentrate, or indecisiveness,*
> *(9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.*
>
> *In addition, the symptoms have to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

The meaning of distress can be explored also at an individual level. Kleinman (1980) developed the notion of 'Explanatory Models' (EMs), a concept that addresses the micro-perspective of an individual's own explanation of the experience of suffering. As health practitioners also develop EMs pertinent to their patients' illnesses and treatment options, it is important for mental health professionals to understand how Chinese make sense of their emotional distress before clinical decisions are taken (see Chan and Parker, 2004). Enquiry about patients' own EMs provides an insight into the interplay between culture and human experiences.

4. *Acculturation*

In the process of migration and acculturation it is reasonable to expect a heightened level of emotional distress. One possible explanation for this is the social isolation that follows being alienated from the mainstream culture. Bhugra (2003) posits a model spelling out the complex interaction of pre-migration, migration and post-migration phases. Mastery of communication skills is crucial for everyday social interactions. Thus, second language competence is an important factor in facilitating integration into the mainstream culture. Another possible source of 'stress' is the lack of culturally familiar pathways to help and support when compared with those in the home town. Does the risk of becoming depressed increase among first generation Chinese? Are second generation Chinese more willing to report their emotional distress as they become more acculturated?

5. Research questions and methods

I outline below the five research questions of my study, I also explain how finding an answer to each question can bridge a gap in existing knowledge.

5.1 Research questions

5.1.1 Do Chinese and Australians experience similar depressive episodes?

This is the most fundamental question to be addressed. Traditional Chinese Medicine asserts a close link between the body and mind which are in turn closely connected to the cosmos. The frequent use of body metaphors by Chinese when describing different emotions which, when in excess, are believed to result in illness. The objective of this study is to ascertain whether less acculturated Chinese are more likely to present with bodily/somatic symptoms to express their depression than more acculturated Chinese. Do the latter resemble Australians when reporting psychological symptoms of depression as a result of their acculturation?

5.1.2 Are Chinese less susceptible to depression than their Australian counterparts?

As mentioned earlier, Chinese favour their culturally sanctioned labels such as SJSR when referring to depressive episodes. Research has demonstrated that Chinese cultural factors lower the susceptibility to depression. However, because of the social dynamics encountered by different generations, protective factors could become risk factors depending on the acculturation at a group level. Global public health campaigners should examine these protective factors more analytically in a transcultural setting in order to develop more culturally appropriate strategies to promote mental health within a multicultural society.

5.1.3. How do Chinese conceptualise their depressive episodes and mental illness?

The underlying illness concepts held by the Chinese may determine how they seek help. How do Chinese explain their depressive experience and mental illness? Cheung (1987) claims that in a clinical sample in Hong Kong (a) those patients (39%) with purely psychological problems tended to use self-directed psychological coping methods; (b) those (22%) who presented with pure somatic symptoms approached Western medical resources; and (c) those (39%) with mixed symptoms consulted psychiatric services much sooner than the other groups. Do less acculturated Chinese attribute their emotional distress more to physical/non-psychological causes compared to the more acculturated Chinese?

The value of transcultural research lies not only in reaching a greater understanding of explanatory models and symptom manifestations of people from different cultures enabling tailor-made interventions to suit individual needs, but also challenges the basic assumption that there is a universal illness experience in relation to depression.

5.1.4. Do Chinese employ similar help-seeking strategies to Australians?

Chinese seeking medical help are more likely than people brought up in non-Chinese culture to complain of somatic symptoms: body metaphors for emotional distress are cited frequently in Chinese culture (Tung, 1994).

In addition, some Chinese believe in letting things take their own course which fits well with the doctrines of Taoism. It is thus important to identify any different patterns of help-seeking strategies among Chinese at different levels of acculturation. Will the more acculturated Chinese subscribe to a Western biomedical model more readily (or are they the people who chose to acculturate more in the first place)? Will the less acculturated Chinese adhere closely to culturally familiar strategies (e.g. Chinese Traditional Medicine)?

5.1.5. Are Chinese less likely to report emotional distress to their general practitioner than Australians?

Cheung (1987) and Lee (1998) argue that one possible explanation for the high prevalence of somatised depressed patients in medical or clinical settings lies in Chinese seeing Western medical professionals in their presumed role of experts of physical diseases. Chinese may therefore deem it inappropriate to discuss their emotional problems with their GPs. It is crucial to find out whether Chinese patients report their emotional distress/ psychological complaints to their GPs.

5.2 Research Methods

This study adopted mixed methods to explore the complex issues behind how culture influenced the conceptualisation of mental illness and the subsequent help seeking strategies among the Chinese Australians. In medical and social sciences research, surveys, questionnaires and other diagnostic measures are frequently used to collect quantifiable data from a large sample; for example, demographics and rates of lifetime depression. Qualitative methods such as interviews or focus groups are often used to obtain more in-depth information about a topic; for example, the context in which the depressive experiences occurred. The two methods represent different ways of knowing, and neither should be regarded as superior to the other. Rather, the two serve to complement each other. Chinese and Australians were recruited for both the survey and focus groups in this study. Attendants of primary health care (i.e. general practices) were given questionnaires which addressed the followings: somatisation and psychologisation attribution, state depression (using the screening tool DMI-10, see Appendix I, Parker et al. 2002; Chan et al. 2007) and lifetime

depression, recognition of depressive symptoms (from a list of 35 common depression symptoms, see Appendix II), acculturation (by SL-ASIA, Suinn et el, 1998) and help-seeking. A total of 16 community focus groups (approximately 90 minutes each) were run to cover different language and socio-economic backgrounds of participants. There were 4 groups of each language category, namely: Cantonese, Mandarin, English-speaking Chinese and English-speaking Australians. The rationale, sampling methods and protocols for conducting focus groups are carefully planned. The development of the two vignettes and the observations made from pilot focus groups are incorporated into the study. Continuous review and revision of qualitative research methodology and recruitment strategies is considered one of its important elements. Recruitment challenges existed in both the quantitative and qualitative phases of this study, i.e. in generating support from general practitioners for the survey and engaging Chinese informants to voice their opinions in focus group discussions.

Data was entered into Statistical Package for Social Sciences (SPSS 13.0), and means etc. calculated for demographic variables as displayed in Table 1.1, Table 1.2 and Table 1.3. (See Parker et al 2005 and Parker et al 2006 for more detail descriptions). NVivo 2 was used, to code the qualitative data (see Chan et al 2005 for a summary of the qualitative data). Translation and validation of the Chinese research instruments occurred through two series of sub-studies. The findings of these sub-studies facilitate some important epistemological insights for cross-cultural research (See Chan et al. 2007 for details).

Table 1.1: Demographics of survey participants and percentage of people with previous depressive experiences

	Chinese		Australians
Level of Acculturation	Low Acculturated Chinese Version N = *256*	High Acculturated English Version N = *129*	English version N = *43*
Mean Age	42.4	30.6	41.5
Age at migration	31.4	13.4	N/A
*SL-ASIA**	2.05	2.72	N/A
Females	57.0%	54.3%	53%
Have previous depressive experiences	29.0%	37.6%	49.2%

* SL-ASIA : Suinn-Lew Self-Identified Acculturation Scale

Table 1.2: Demographics of focus group participants

Level of Acculturation	Low Acculturated Chinese version		High Acculturated English version)	Australians
Focus group language	Mandarin N = 26	Cantonese N = 33	English N = 17	English N = 25
Mean age	59.4	41.1	29.4	47.0
Age at migration	48.7	25.8	17.9	N/A
*SL-ASIA**	1.90	2.72	2.84	N/A

* SL-ASIA : Suinn-Lew Self-Identified Acculturation Scale

Table 1.3 Help-seeking in response to experiencing a likely lifetime episode of depression for the Low Acculturated Chinese, High Acculturated Chinese and Controls.

	Low Acculturated Chinese N = ***252*** A	High Acculturated Chinese N=128 B	Australian controls N = 140 C	Chi-square analyses		
				A vs C	B vs C	A vs B
General Practitioner	28.4%	35.0%	57.4%	11.0**	4.8**	0.5
Psychologist	17.9%	22.5%	29.5%	2.4	0.6	0.3
Psychiatrist	10.4%	12.5%	29.5%	7.4*	4.0*	0.1
Chinese herbalist	3.0%	2.5%	4.9%	0.3	0.4	0.02
Friends or family	22.4%	5.0%	13.1%	0.9	1.8	4.3*
Sought no help	38.8%	47.5%	24.6%	0.8	5.7*	3.0

*$p < .05$, ** $p < .01$, ***$p < .001$

6. Integrating data from the survey and focus groups

When interpreting the themes of help-seeking strategies suggested by the focus group informants, I made an attempt to detect any similarities and differences in the patterns as compared to the responses obtained from the survey questionnaire. These strategies were built upon who the helpers were. The narratives followed a natural sequence according to the informant's own EMs, extending from what the 'self' could do to help to what the 'professionals' could do. GPs were frequently mentioned as the first point of professional contact if the condition was perceived as a medical concern. Despite the diverse views surrounding the use of psychiatric services, seeking help from a family doctor to relieve the more obvious somatic symptoms appeared to be a recurrent theme in all focus groups.

The following was a typical response:

> *'I think seeing a doctor is necessary, for example difficulty sleeping. To a certain extent, doctors can help her.'* (CV: 133)

Those informants, with first hand experience of depression, had known friends or relatives in similar circumstances, or had learnt about it through the media, Internet or other sources, recommended specialist care such as psychiatrists or psychologists. One Mandarin-speaking female, who had consulted a psychiatrist through interpreters, shared her experiences towards the end of the focus group meeting. Many Chinese informants raised the issue of shame in relation to the young mother's over-concern with gossip in the first vignette and the unemployed male not being able to support the family in the second vignette. Non-medical strategies were often suggested such as engaging in leisure activities with friends or socialising with people in the community. The term 'helper' in these cases was extended to non-medical helping professionals such as social workers, migrant settlement workers, and multicultural health workers. The importance of 'self-help' was another common theme. In several instances, a certain degree of moral judgement was leveled at the person in the vignette for having put him/herself in such difficult circumstances. For example:

> *'Wasn't it a mother's responsibility to care for her kids?'* (MA: 37)

'He must be very picky when he looked for jobs! Why wouldn't he just take any job?' (MM:180)

It may be that the above value judgements reflect the cultural values of the informants.

7. Help-seeking strategies

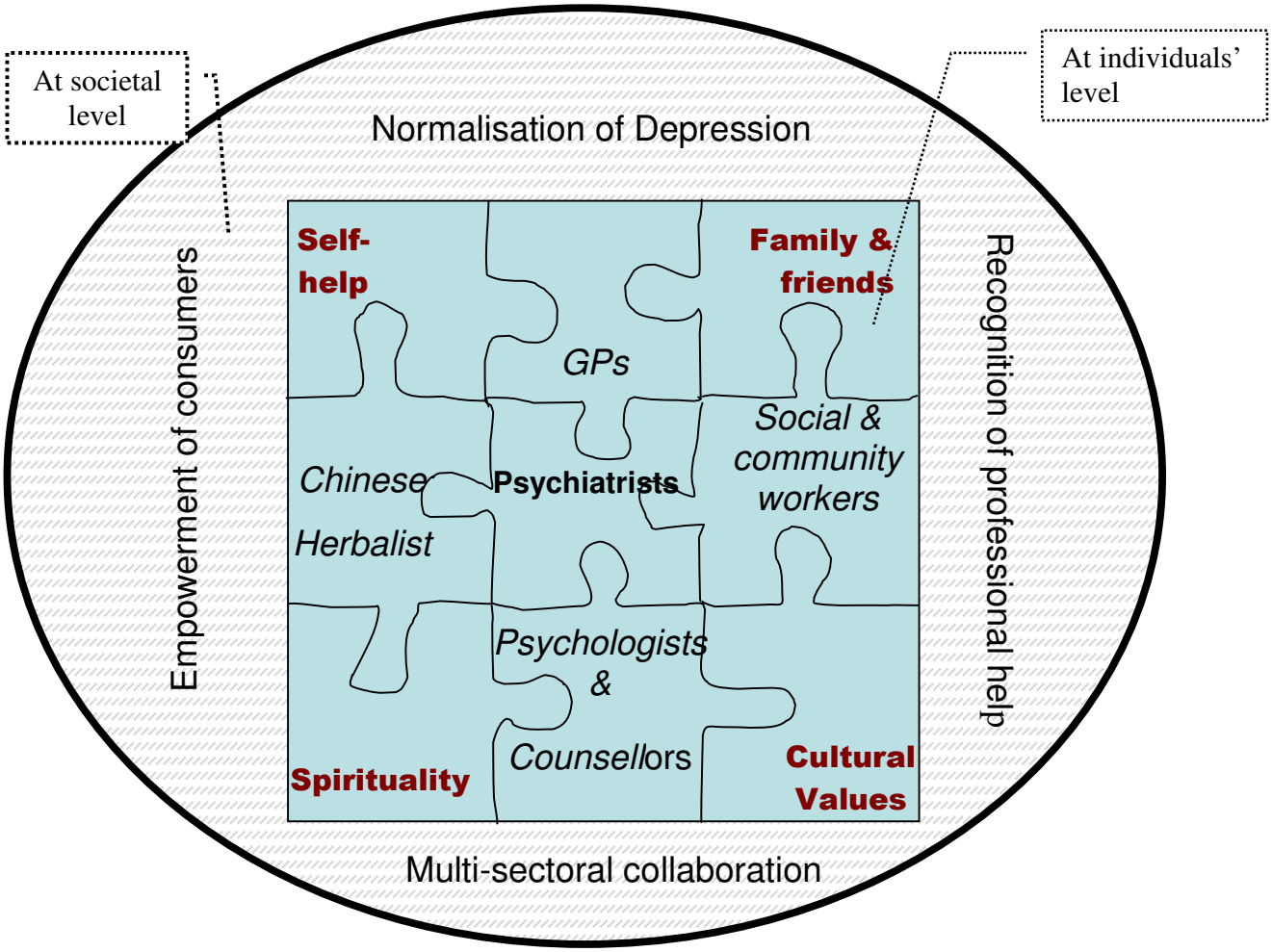
The following section is my interpretation of major themes collected at the focus groups. Examples of original narratives by the focus group participants are provided in the Chapter 6 of my thesis.

7.1 Help-seeking Puzzle

In Figure 1, the central piece of the puzzle represents psychiatrists for whom patients require referrals from GPs in Australia's medical system. Psychiatrists are usually not the first port of call of professional helper. The four puzzle pieces attached to this centrepiece represent the professional helpers mentioned in the focus groups, namely GPs, psychologists/counsellors, Chinese herbalists and social/community workers. These professional services usually attract a fee, although membership/activity fees for some community groups are only a token few dollars. These services were mentioned by members of different focus groups, due to the levels of acculturation of individual participants, the activities suggested could be different.

GPs, Chinese herbalist, psychiatrists and psychologists were response options in the questionnaire regarding professional help seeking. There was a response item 'other' to allow participants to write down 'helpers other than those listed'. Among examples of others nominated as sources of help were: 'close friends', 'my mum', 'my friends and my sister', 'talk to my wife', ' talk to the church minister', 'Buddhist chant', 'read self-help book', 'get through it myself', 'homeopath', 'talk to early childhood nurse'. So the survey results strongly suggest the availability of helpers outside the orthodox mental health field. Some Low Acculturated Chinese focus group participants mentioned their visits to Hong Kong or China. The theme of self-help was prevalent in their discussion.

Figure 1: Help-seeking puzzle



For the focus group study, theme saturation was the criterion for ceasing recruitment. I was reasonably confident that the narratives sampled covered a considerable number of themes. Some themes were common in groups from very different age, language and cultural backgrounds.

The four corners of the Help-seeking Puzzle are 'family and friends', 'self', 'spirituality' and 'cultural values'. They represent help at the non-professional or non fee-incurring level, i.e. help relatively easy to access if the individual chooses to do so. They are also the preferred strategies when

the episodes are mild or transient. In the survey, some participants reported that they found their beliefs, including their religious and cultural values, helpful in times of hardship.

7.2 Attitudes and Beliefs

Around the puzzle pieces in Figure 1, encompassed by the oval, are the four overall approaches to depression. These strategies, nominated during the focus group discussion, require a change of attitude not only in those needing help but also in the helpers and the surrounding community i.e. those that the person in need rubs shoulders with in the public domain.

1. 'Normalisation (or De-stigmatization) of Depression' signals recognition of how common this condition is and encourages a more empathetic approach to its sufferers.
2. 'Recognising Professional Help' signals awareness of the different avenues of professional help and the fact that clinical depression is treatable if the right help is sought promptly. This is especially true for the prevention of suicide.
3. 'Multi-sectoral Collaboration' signals the combined effort of both medical and non-medical professionals working together to promote mental health and mental health literacy for everyone, including the self, family and friends of the depressed and spiritual leaders. At the professional level, encouraging referrals within the health professions are equally important.
4. 'Empowerment of consumers' signals the major step forward in the healing process. Consumers need to be encouraged to exert more influence on the very system that provides services for them. Both Chinese and Australian informants saw it, by reaching out to help a person in a similar situation, this results in the depressed person progressing towards managing their own episodes. Only informants from the Australian groups spoke of advocacy as part of their empowerment and journey to healing, which is linked to the strong value accorded human rights in a democratic Western society.

In summary, to describe the 'oval' encircling the 'Help-seeking puzzle' more precisely, it symbolizes a higher level of help, i.e. the attitudes and values pivotal to managing mental well-being.

The choice of 'helpers' was closely related to the EMs of the informants. For example, one of the reasons why Chinese informants opted against medical intervention is that while they may have acknowledged the depressed state of the person in the vignette, they failed to label such a

'mood not good' condition as requiring medical intervention. Thus they may turn to lay helpers for emotional support or practical assistance.

7.3 Overview of help-seeking strategies

It is apparent that many low acculturated Chinese perceive depression as an emotional state; thus it is not unexpected that they do not seek medical advice. Frequently, when their somatic symptoms develop to a point where they start to cause 'unease' or 'discomfort', consulting a family doctor does become a priority, a means of 'restoring comfort'. The concept of imbalance is highly prevalent in the Chinese informants' narratives; someone might be 'out of balance' with the cosmic force *yin/yang* or be experiencing 'psychological imbalance' or 'hot/cold imbalance'. Given that the balance concept is deeply rooted among the Chinese, an explanation of 'imbalance of brain chemistry' should not prove too foreign a concept if offered by a Western trained professional. However, there is a longstanding cultural belief that excessive expression (indulgence) of negative emotions can cause illness. Depressive experiences, when articulated openly, tend to attract little sympathy, let alone empathy. As one informant put it,

> "*…the reason I don't feel sorry for this guy [the unemployed person in the second vignette] in the same situation….*
> *And [when] I migrated to Australia… my Dad just go and do it [take up a job that requires less qualification than you have] and they [my Dad and his friends] don't give a crap what other people think….*
> *And I think if they can do it at such a kind of close to their fifties and why can't all these people [those in similar situations to the vignette]?" (ER: 306)*

The strong stigma attached to mental illness serves as yet another deterrent from seeking help early. Stigma represents the social response to depression and is shaped by cultural interpretation (Good and Kleinman, 1985). However, among the highly acculturated groups, many informants who were educated in Australia had more knowledge of this condition. Having enjoyed contact with both Chinese and mainstream cultures, many of them are more resourceful and have more choices in seeking professional advice.

8. Major Research findings

1. As shown in the focus group narratives, the less acculturated Chinese are less certain about the Western psychiatric diagnosis of 'depression' whereas the highly acculturated Chinese were more familiar with Western medical terminology.

2. The use of the vignettes has proven powerful in eliciting discussion of everyday examples. Informants, Chinese and non-Chinese alike, could relate to the two vignettes suggesting that 'depressive experiences' are similar across the Chinese and Controls. However, informants from different cultural backgrounds may not uniformly call their condition as 'depression' described in Western diagnostic manuals.

3. In the survey, participants who had previously experienced a depressive episode were asked to nominate their most troubling symptoms. Results indicated that the top six symptoms were very similar across all three subgroups (Low Acculturated Chinese, High Acculturated Chinese and Australians), though the order of ranking for individual groups was different. The survey findings established the proposition that some depressive symptoms are culturally more salient to the Chinese than to the Australian Controls and vice versa. The most complained of symptom among the Chinese was 'insomnia' which is consistent with previous research findings. Non-Chinese participants nominated the cognitive symptom 'anxious and tense' as the top troubling symptom. Somatic symptoms were frequently reported by the low acculturated Chinese in the focus group narratives.

4. The survey established that those who had experienced a depressive episode to nominate their explanatory models (EMs). Regardless of ethnicity, some common themes were cited such as 'life stress', 'work-related stress' and 'relationship issues'. Both the low and highly acculturated Chinese nominated 'family challenges' as a leading cause of their emotional distress. The Australians were more likely than the two Chinese subgroups to relate their depressive experience to other health concerns. During focus group discussion, the theme of 'family challenges' was also mentioned repeatedly by the Chinese groups as the source of stress.

5. The 'interdependent' nature of the social roles at play in a Chinese family is apparent in the study results. Kleinman (1980) first coined the term 'Explanatory Model' in 1980 and now, after more than two decades, mental

health professionals have come to (a) recognise the importance of patients' own explanatory model to subsequent help-seeking behaviour (WHO 2002), and (b) develop an integrated model of concepts of depression, taking into consideration patients' own explanation of events (see Appendix III for this model).

6. The survey findings showed significant differences in the self-reported rate of 'depressive episodes' between the different cultural subgroups with the highest rate within the Australian Controls (49.2%) followed by the High Acculturated Chinese subgroup (37.6%), and the lowest rate among the Low Acculturated Chinese subgroup (29.0%). The results of statistical analysis of the likelihood of participants seeking professional help for persistent episodes suggest an increasing trend of consulting psychologists/counsellors with increased acculturation. Perhaps the more acculturated Chinese are in touch with their depressive experiences and have a more positive attitude towards seeking help from the mental health system. However, the rate of having taken antidepressants to relieve depressive symptoms remained low among both Chinese subgroups. The meanings of such a correlation remain unaddressed by the quantitative findings.

7. Reviewing the narratives of the Chinese and Australians who have personal depressive experiences or have known someone with such experiences sheds light on the observed phenomenon. What kind of help were Chinese seeking when they consulted mental health professionals as well as lay helpers? Qualitative data demonstrated that Low acculturated Chinese not only draw upon both Western medical and Traditional Chinese herbal remedies, but also culturally familiar services in the community or religious organizations to manage their emotional distress. Chinese family values and Confucian teachings are also important sources of support during stressful life events. The survey results indicated that both Chinese participants and the Controls were likely to recognise depressive symptoms. However the more acculturated Chinese tended to recognise the cognitive symptoms more. There was no link between level of acculturation and previous depressive experiences. Consistently across all subgroups participants with experience of depression were more likely to recognise depressive symptoms than those who had never experienced depression.

8. Chinese were less likely to talk to their GPs about their psychological problems. Focus group informants explained the phenomenon as follows: most people who consult their GPs have the impression (a) that GPs will only prescribe medication, and (b) that they are usually very busy. However

informants also stressed the importance of establishing a close bond before they would feel comfortable encouraging their friends to consult a GP. The level of trust required for someone to disclose their emotional distress was revealed as quite high. This is not surprising for Chinese culture has long discouraged the expression of negative emotions.

9. Some focus group participants were concerned about the mismatch between the cultural backgrounds of patient and helper which could lead to misdiagnosis.

10. Those who had taken part in a support group found it helpful. It could prove an important source of knowledge about the availability of services and means of emotional support. All of this information is valuable to assist policymakers to understand why some Chinese favour consulting health professionals such as psychiatrists, GPs and psychologists while others don't. Health promotion could usefully aim at correcting negative perceptions, for example explaining the mechanism of medications and clarifying the roles of the various mental health professions. Some Chinese informants said they preferred to talk to their friends; but friends or family members may lack the mental health literacy required to provide the often urgent help needed. Health talks are greatly welcomed by the Chinese at the lower acculturation level so health promotion campaigns delivered in Chinese could be well worthwhile.

9. Summary of Implications

9.1 Depressive Experiences

From the findings of the survey it is apparent that while Chinese and Australians have similar core depressive symptoms, culture shapes their differing attentiveness to and interpretation and presentation of these symptoms, for example as somatic or psychological. The notion of 'linguistic saliency' is widely documented in language development. Children living at the North or South Poles, for example, acquire rich vocabularies for different forms of ice and snow. I transfer this concept to the area of human emotions and their *verbal* expression as guided by their 'cultural saliency'. Chinese children are negatively reinforced to *talk* about their negative emotions but positively reinforced to express them using body metaphors, for example 'I have an angry liver' instead of 'I am angry'. Chinese adults are more likely to talk with someone who has a cultural understanding of what s/he means by '*gan huo* 肝火' (literally 'liver fire'). The fact that highly acculturated Chinese-Australians voiced their preference for therapists with a good grasp of Chinese cultural nuances may sound like 'stating the obvious'. But it is in fact a quest for cultural competency among the mental health professionals.

The inappropriate use of the term 'cultural competency' can cause discomfort among Anglo-Celtic and other mainstream health professionals. To appreciate the real significance of cultural competency we can imagine if cultural competency had not been incorporated into mental health care. Misdiagnoses resulting in delayed treatment or malpractice can have serious consequences, for example fatality from suicide. It was commonly agreed by both Chinese and Australian informants in this research that trust was the ticket to accessing sensitive information. One aspect of cultural competence is what health professionals call 'social competence' in history taking, a skill that is fundamental to establishing rapport during any diagnostic interview. Lacking rapport, patients may feel misunderstood or disrespected which undermines an optimal therapeutic relationship. Early termination of or refusal to seek treatment may be the outcome. This can happen to any patient irrespective of cultural or linguistic background.

9.2. Concepts of Illness

If illness experiences are shaped by culture so too are concepts of illness. Prevalent among the low acculturated Chinese were the concepts of 'hot/cold imbalance', 'emotional imbalance' and 'psychological imbalance'. They can be traced back to the cultural belief in external *yin/yang* forces in the cosmos and the internal *yin/yang* balance of *qi* in the body. The Chinese commonly make an association between Human and Nature and over the course of their history cultural/mythical/spiritual elements that emerged over 5,000 years ago have become intertwined with this connection. The influence of Confucianism, Buddhism, Taoism and Christianity together with geographic, social, political and economic changes such as the Cultural Revolution have added vibrancy to the explanatory models Chinese use for their experiences of suffering. This was illustrated in the focus group narratives. The stories told by the highly acculturated Chinese-Australians reflected the reality of those straddling two cultures. The non-Chinese groups represent the worldviews of those who grew up in Australia.

An understanding of their lay concepts of illness made it easier for me to interpret the observed helping-seeking strategies that Chinese employ to deal with their emotional distress. I conceptualised the findings from the survey and the focus groups using a 'Help-seeking Puzzle'. If mainstream health professionals believe that consultation with a psychiatrist should be the 'centre piece' of care, the pressing task is for them to collaborate with bilingual Chinese GPs and psychologists to ensure patients are referred to the most appropriate specialist care. But from my point of view as a bilingual, bicultural medical anthropologist, it is preferable to describe the different options available to a depressed Chinese and indicate that different individuals in similar circumstances may well opt for different forms of help. The action taken will depend on the severity of the case and how one makes sense of the circumstances. Sometimes more than one form of help is required to deal with the complex mechanisms governing human emotions. I believe in providing as much support as possible once the person has decided where to start or who to approach first. It is evident that I am thus not only advocating a pluralistic non-discriminatory approach but also an integrated approach that acknowledges that a person may be facing difficult circumstances that cannot be fixed by medicalising either the somatic or psychological symptoms.

9.3 Bridging Services

Throughout the discussion, I have made suggestions regarding different forms of services at various levels from personal, professional through to community. I want to emphasise that under-utilisation of mental health services by Chinese-Australians is an issue *beyond access***.** Common structural hurdles to services like 'inconvenient opening hours of clinics' or 'long waiting time to see specialists' did not emerge in the focus group narratives. However, this does not imply the non-existence of these hurdles but rather reflects a more serious problem:

Is there actually something to access?

Are existing services culturally sensitive or appropriate for the Chinese communities?

I have cited examples of models used in other countries with a predominately Western or Anglo-Celtic culture facing an increasingly diverse ethnic composition similar to the Australian context. Earlier research findings strongly suggest that there are obvious language difficulties and a *hidden cultural gap* in the services. The next step is to implement programs to bridge identified service gaps. The **'**Bridge Program' in New York (Chen et al. 2003) provides a sound model. This program could work here if bilingual and bicultural mental health workers were to be available to act as the 'bridge'. But, what about other ethnic groups in which bicultural health workers are less readily available? Since the use of both bio-medical Western and traditional medical systems is very common among the Chinese, an integrated model that blends indigenous healing practices, primary care and specialist care could also work well. The indigenous healers would provide holistic care that treats both the body and the mind. During the course of treatment, the patient's primary physician would be kept closely updated on progress and if the condition requires more acute medical intervention, the doctor could then refer the patient to a psychiatrist. An open dialogue between Western doctors and the traditional healers would serve as a bridge to enhance cultural competency in patient care.

A more direct approach would be for clinicians to become the *bridge* between patients and medical services, i.e. all Western trained doctors learn the generic skills required to manage patients from diverse cultural

backgrounds. The new UNSW undergraduate medical program is a relevant example. Since 2004 the new curriculum has incorporated 'cultural competence' into the teaching and learning process through all its phases and domains. Multicultural Mental Health Australia provides an on-line resource to help mental health workers raise their 'cultural awareness' (A Cultural Awareness Tool Kit, Multicultural Mental Health Australia, 2002). The American Medical Student Association (2006) have posted on their website different scenarios to share cultural competence with fellow students. These initiatives acknowledge that:

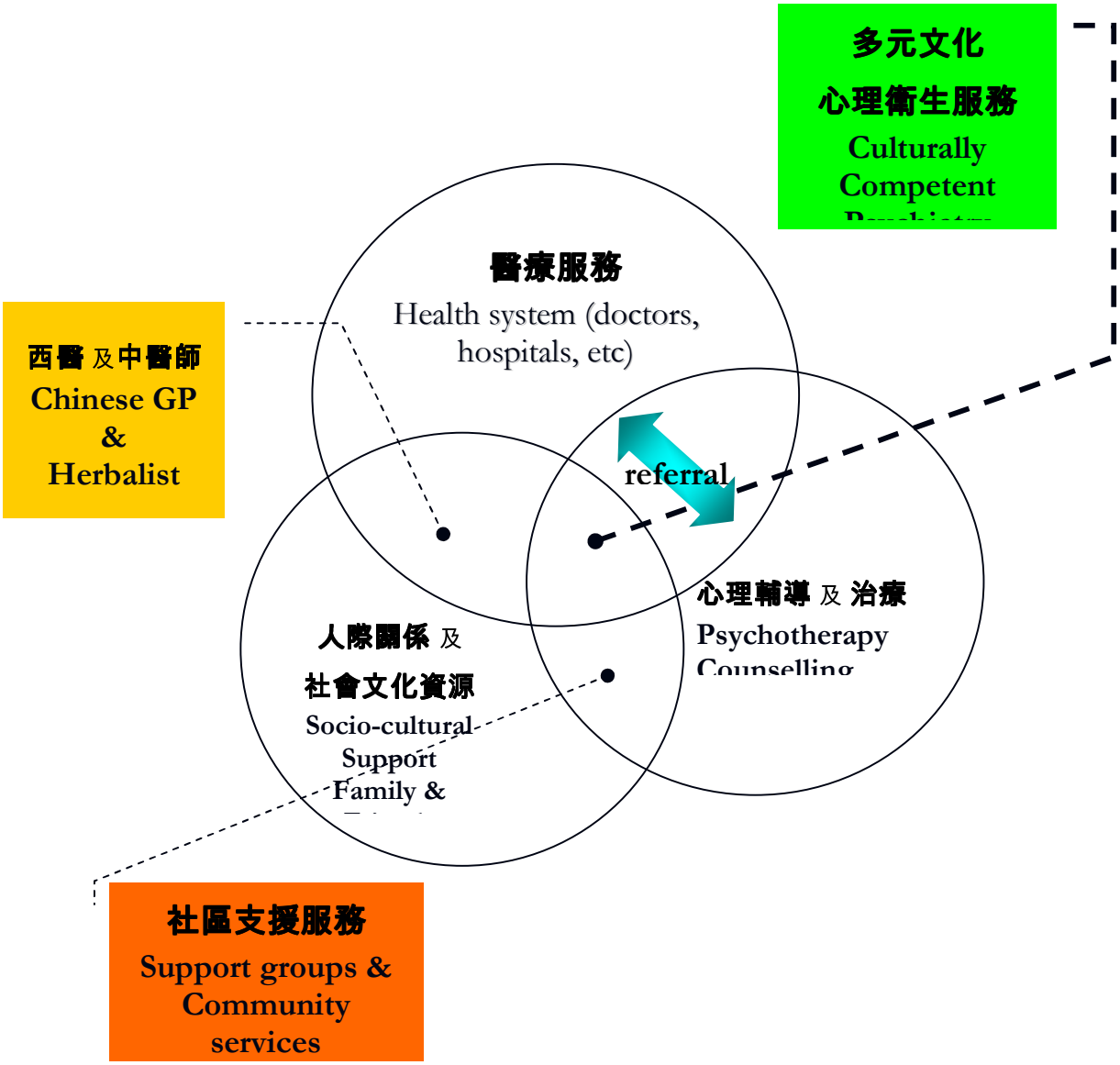
> *Rather than being insulted by another culture's perspective, culturally competent providers welcome collaboration and cooperation.*

9.4 Cultural Competence

Culturally competent mental health care for Australia's multicultural communities is the ultimate goal, the highest standard (See Figure 2 for my model of 'Cultural Competent Psychiatry'). To many mainstream mental health workers it may seem remote. Meeting the demands of heavy caseloads may already put workers own mental health at risk, without adding the challenge of cultural competency. To press for additional government funding for more staff and resources requires not only the advocacy of consumers and carers at the grass roots level but also evidence-based research to support the claim of existing service gaps. As outlined earlier, stakeholders in research funding in 2000 perceived scientific investigation in mental health in CALD communities as low priority (Jorm et al, 2002). The remaining option is for CALD consumer and carer groups to agitate more forcefully. I cannot speak for other CALD communities but allusions made during the focus groups to concepts like 'advocacy' and 'assertiveness' sounded foreign to the Chinese informants. Apart from the language hurdle, the cultural hurdle seems enormously difficult for them to jump over.

Internationally, UNESCO's (UNESCO, 2001) *Declaration of Cultural Diversity* affirms that the cultural rights of people of every background should be respected. And locally a group of dedicated public health campaigners in South East Health (SEH) have published a tool kit titled *Four Steps Towards Equity* (Equity Project Team, SEH, 2003) with the aim of assisting health professionals and organisation managers to embed the concept of equity at all levels of health services. This should help to make culturally competent health care more achievable.

Figure 2: Cultural Competent Psychiatry



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後語
Endnote

To be a Chinese man 'jun-zi' Confucius said,
"Do not impose upon others, what you would not like them to do to you". Analects 15:22

孔子云: *己所不欲, 勿施於人.*

To be culturally competent, an American medical student was advised,

"Do not treat the patient in the same manner you would want to be treated."
American Medical Student Association (2006)

作為身處澳洲的華人、希望我接觸的人會用英語或華語問一聲,

'你想我怎樣待你呢 ?'

As a Chinese-Australian, I would like to be asked, in either Chinese or English,
"How do you want to be treated?" *Bibiana Chi-Wing Chan*

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Appendix 1: Screening of 'Depression for the medically-ill' *(English version)*

MEDICAL ILLNESS IMPACT QUESTIONNAIRE

Please consider the following questions and rate how true each one is in relation to how you have been feeling **lately** (i.e. in the last three days) **compared to how you usually or normally feel.**

Tick the most relevant option

	Not True	Slightly True	Moderately True	Very True
1. Are you stewing over things?				
2. Do you feel more vulnerable than usual?				
3. Are you being self-critical and hard on yourself?				
4. Are you feeling guilty about things in your life?				
5. Do you feel as if you have lost your core and essence?				
6. Are you feeling depressed?				
7. Do you feel less worthwhile?				
8. Do you feel hopeless or helpless?				
9. Do you feel more distant from other people?				
10. Do you find that nothing seems to be able to cheer you up?				

Appendix 2: Symptoms of Depression

The following is a list of symptoms people may have when they are emotionally distressed. For each item, please tick the appropriate box to indicate, in your opinion, whether someone experiencing 'Depression' would be likely to show such a symptom.

Symptoms	Definitely	Sometimes /to some degree	Not at all
1. Looking sad and depressed			
2. Feeling helpless			
3. Think too much			
4. Feeling guilty			
5. Less able to laugh			
6. Fatigue			
7. Feeling angry			
8. Poor concentration			
9. Feeling life is not worth living			
10. Slowed physically			
11. Feeling withdrawn			
12. Loss of appetite			
13. Feeling bad about self			
14. Loss of essence and energy			
15. Heaviness in the chest			
16. Feeling anxious and tense			
17. Headaches			
18. Disturbing dreams			
19. Bored and unhappy			
20. Having decrease in their self-esteem			
21. Thoughts of death			
22. Feeling like giving up and hopeless			
23. Feeling suicidal			
24. Feeling agitated and having to keep moving			
25. Unable to look forward to things			
26. Loss of weight			
27. Having loss of self-confidence			
28. Body aches and pains			
29. A lack of interest in doing things			
30. Easily irritated			
31. Inability to sleep			
32. Feeling everything is not under control			
33. Talking very softly			
34. Breathlessness			
35. Feeling depressed			

Appendix 3: Model for integrating concepts in depression

附錄 3：融匯病者詮釋方法的模式