

**CHINESE WOMEN'S EXPERIENCES OF ACCESSING MENTAL HEALTH
SERVICES**

by

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Abstract

Research worldwide has found the existence of factors adversely influencing Chinese communities' access to mental health services. Stigma, shame and 'loss of face' have played a major role in the underutilization of mental health services by Chinese communities. However, there is little research available in Canada that examines mental health and the general adult Chinese population, particularly gender effects. The purpose of this qualitative research study was to examine Chinese women's experiences of access to mental health services in an urban context in British Columbia. This study was to seek the perspective of Chinese women and providers as to what were the challenges to and facilitators of Chinese women's access to mental health services. Interpretive description was used as the research method for this study and enabled an analytic framework formulated from existing knowledge in the field. This assisted in developing knowledge about Chinese women's illness experiences related to access of mental health services. Purposive sampling was used. In-depth interviews with 7 Chinese women, 2 non Chinese women and 2 health care providers were conducted and the data analyzed. Five themes emerged through the data: 1) stigma and mental illness, 2) social supports: connections with families and friends and the double edged sword, 3) language and access, 4) lack of coordinated, seamless care and the intersection with mental health literacy and 5) health care providers and peer support: navigating mental health services. From these findings, several recommendations were made to reduce stigma and improve access to mental health service. Nurses need to provide culturally competent care, for example, by using professional interpreters when appropriate. In addition, nurses need to be aware of mental health services and other relevant resources inside and outside of the health care system.

Nurses are in a good position to provide education to increase mental health literacy and reduce stigma. Also, nurses can advocate and collaborate with community agencies, policy decision-makers and other health care professionals to enhance access to services.

Preface

This research had been approved by the University of British Columbia Behavioural Research Ethics Board (UBC BREB). UBC BREB certificate number: H10-01996.

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CHAPTER ONE: INTRODUCTION

Background to the Problem

In Canada, Asian immigrants particularly those who are Chinese¹, have been the source of over half of all immigrants since the early 1980s (Fung & Wong, 2007). The Chinese community in Canada has a lengthy settlement history (Lai, 2004) and belongs to the largest ethnocultural group (Statistics Canada, 2006; Wong & Tsang, 2004). According to Statistics Canada (2006), the population of Canada is 31,241,030 that comprised of 1,216,570 Chinese individuals. The population of British Columbia is 4,074,380 with a population of 407,225 Chinese. In the census metropolitan area of Vancouver there are 381,353 Chinese individual residents, which indicate there is a high proportion residing in a concentrated urban area.

One in five people of ethnic minority are affected by mental health issues in Canada (Here to Help.bc.ca, 2006). However, two thirds of people with a diagnosable mental disorder in North America do not seek treatment (Drake, Merren, & Lynde, 2005; Scheffer, 2003). Therefore the actual number of Canadians affected by mental health issues may be larger than reported and remains undefined. In North America, it is well documented that Chinese individuals tend to underutilize mainstream mental health services (Chen & Mak, 2008; Hsu & Alden, 2008; Leong & Lau, 2001; Yang, Phelan, & Link, 2008; Yeung et al., 2004) relative to the population size.

Research worldwide has found the existence of factors adversely influencing Chinese communities' access to mental health services. Stigma, shame and 'loss of face'

¹ I am using the term "Chinese" to refer to the group of people who belong to the ethnicity of China (China, Hong Kong, Taiwan, Singapore, other parts of the world) (Lin. Tseng & Yeh, 1995).

have played a major role in the underutilization of mental health services by Chinese communities in Canada, United States, Taiwan and Australia (Abe-Kim, Takeuchi, & Hwang, 2002; Abe-Kim et al., 2007; Chen & Mak, 2008; Drake et al., 2005; Hsu & Alden, 2008; Kung, 2004; Leong & Lau, 2001; MacLachlan, 2006; Ran, Xiang, Simpson, & Chen, 2005; Scheffer, 2003; Wynaden et al., 2005; Yeung et al., 2004). Stigma occurs during the onset of psychological symptoms and being labeled when receiving treatment for mental health issues (Yang et al., 2008). 'Loss of face' refers to a threat to the homeostasis of the family (Hsiao, Klimidis, Minas, & Tan, 2006). Individuals are concerned with how others perceive them as well as concern for shame to their family (Abe-Kim et al., 2007; Chen & Mak, 2008; Hsu & Alden, 2008; Kung, 2004; Leong & Lau, 2001; Scheffer, 2003; Wynaden et al., 2005; Yeung et al., 2004). This may cause Chinese people to be more reluctant to admit to mental health problems (Chen & Mak, 2008; Hsu & Alden, 2008). These factors influence Chinese people's attitudes of mental health on themselves and others (Herrick & Brown, 1999).

Cultural barriers such as relevance, credibility of mental health treatment and denial of need for service (Kung, 2004) affect utilization of mental health services. As well, practical barriers have an affect, such as knowledge about how to access services and language (Abe-Kim et al., 2007; Drake et al., 2005; Kim & Keefe, 2009; Kung, 2004; Leong & Lau, 2001; Spencer & Chen, 2004; Yeung et al., 2004).

For Chinese communities, lack of trust in mental health services is a barrier to seeking treatment (Abe-Kim et al., 2007; Ran et al., 2005; Spencer & Chen, 2004). In Chinese communities, there is a tendency to seek help informally from social networks

such as family, extended family and friends for psychological problems (Akutsu, Catillo, & Snowden, 2007; Cheung, 1995; Spencer & Chen, 2004; Yang et al., 2008).

One other assumed barrier for the Chinese communities in North America is a lack of mental health literacy (Abe-Kim et al., 2007; Hsu & Alden, 2008; Leong & Lau, 2001; Song, Chang, Shih, Lin, & Yang, 2005; Spencer & Chen, 2004; Yeung et al., 2004). Mental health services are often used as a last resort after seeking help from social networks, alternative practitioners and primary care physicians (Yeung et al.). The use of informal support systems may delay individuals from help seeking with professionals for their mental health issues/concerns until symptoms become severe (Spencer & Chen).

According to MacLachlan (2006), Chinese people's service needs are not met because in Chinese culture there is a tendency to lack recognition for some problems such as mental illness. For example, there is reluctance to engage in health services as mental illness is seen as something negative. This is due to shame associated with mental illness and the need to "save face" (MacLachlan). People from Chinese community with a mental illness often indirectly access mental health services by accessing health professionals with their physical complaints (Wynaden et al., 2006).

From my clinical practice as a clinician working in community mental health, I have observed how individuals, including some who are Chinese, often wait until a crisis occurs to access mental health services. Chinese people in North America tend to delay or avoid seeking professional mental health treatment until their conditions are severe and all resources are exhausted (Akutsu et al., 2007; Cheung, 1995; Hsu & Alden, 2008; Yang et al., 2008; Yeung et al., 2004). There is delayed mental health service use and services are sought as a last resort, therefore the severity of functional impairment and

mental health problems may be aggravated due to limited help-seeking behaviour (Kim & Keefe, 2009). Interestingly, Chinese women are more open and likely to seek help (Chiu, 2004) for mental health concerns than men. Some common mental health disorders such as depression, eating disorders and anxiety are more prevalent in Chinese women (Tang & Tang, 2001).

Existing research generalizing Asian communities does not entirely represent the beliefs and practices of each individual Asian cultural group. This statement stems through observations made while I was reading many research articles for this thesis. As well, research from other countries does not necessarily imply the outcomes are the same in Canada. Current immigrant mental health research focuses on risk factors related to the distribution of illness and service-related challenges. There is little research examining illness experiences (Simich, Maiter, & Ochocka 2009). It has not been well documented whether ethnic minority groups have equal access to and use of the health care system (Tiwari & Wang, 2008) in Canada, particularly mental health services.

Purpose of Study

The purpose of this research study was to examine Chinese women's experiences of access to mental health services in an urban context in British Columbia. The findings of this study will have implications for nursing practice, education, research and policy.

Research Questions

The overall question that underpinned this study is, what are Chinese women's experiences of access to mental health services. In addition there are two sub-questions: i) From the perspective of Chinese women and providers what are the challenges to and facilitators of Chinese women's access to mental health services; and,

2) What are the implications of the findings for nursing practice, education, research and policy. At present, little is known about Chinese women's experiences and we need to know more about those experiences.

Research Method

The research method chosen for this study is interpretive description (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997), which utilizes aspects of grounded theory, naturalistic inquiry, ethnology and phenomenology (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). This research method is an approach to inquiry about human health and illness experiences for the purpose of developing nursing knowledge (Thorne et al., 1997). Interpretive description is an appropriate research method for this study as it draws upon principles of nursing profession as its philosophical underpinnings (Thorne et al., 1997). It enables an analytic framework formulated from existing knowledge in the field. This is obtained through in-depth interviews and draws on the existing literature related to access to mental health services. A key element of this research method is that a preliminary analytic framework is not static. Its parameters shift as the study progresses so the inductive progress can reveal insights not included in the preliminary framework (Thorne et al., 1997). Interpretive description was an appropriate approach for this study as it can contribute directly to our understanding of how people experience their health and illness and what nursing can do to make a difference (Thorne et al., 1997).

Organization of Thesis

In this chapter, an introduction was provided along with the central problem and research question. In Chapter Two, I review existing literature related to accessing mental health services. I analyzed and looked for gaps in the literature. In Chapter Three,

interpretive description as a research method is presented. There is a discussion on study recruitment, data collection and data analysis. In Chapter Four, I outline findings based on the analysis of data provided through in-depth individual interviews and provide a discussion. In Chapter Five, implications and recommendations in relation to nursing practice, education, research and policy are discussed. In addition, a conclusion to the study is presented.

CHAPTER TWO: LITERATURE REVIEW

Introduction

In the following literature review I examine published research related to the research questions and establish the context of the present study. The review assists in highlighting relevant research and gaps in the literature. I provide an overview of the literature on Chinese culture, stigma, and research conducted in Canada related to access of mental health services and Chinese women. As well, I discuss the gaps in the literature that were found and provide a summary.

Chinese Culture

Philosophical and Religious Constructs

Values in Chinese culture² are rooted in the philosophical and religious constructs of Confucianism, Taoism and Buddhism (Lam et al., 2010). Confucianism is characterized by ethical and moral values, filial piety and encourages moral excellence and cultivation of harmony within self, family, society and universe (Lam et al.). In Confucianism, mental illness occurs when relationships are not harmonious (Lam et al.). Maintaining harmony is important in Chinese culture. Individuals with a mental illness are usually discriminated against and ostracized as having deviant behaviours. This is attributed to a character flaw or low moral standards (Fung, Tsang & Chan, 2010) and hence harmony is not being maintained. Taoism is based on human beings following natural laws and the Way (or Tao) and being humanistic by following human laws (kind, polite) (Lam et al.). In Taoism, mental illness is perceived as a pattern of disharmony

² In this thesis, I define culture as values, practices and attitudes within a group of people. Culture is a dynamic lived experience that shifts over time. It is shaped/influenced by societal, political and historical factor (Anderson & Reimer Kirkham, 1999).

within a person's body and illnesses, for example depression is seen as a "weakness" in spiritual strength (Lam et al.). Buddhism follows the belief that performing good deeds will earn positive consequences and doing bad things will result in negative repercussions (Lam et al., 2010; Wang, Tse & Michalak, 2009). Mental illness is stigmatized in Buddhism as it is perceived as a disability resulting from being punished for wrongdoings in a past life (Lam et al.).

Cultural values

Traditional and contemporary Chinese culture emphasizes collectivism, centrality of family and hierarchical relationships (Jim & Pistrang, 2007; Tsang, Tam, Chan, & Cheung, 2003; Wong & Tsang, 2004). Filial piety is a central component to family, which is the love and respect for one's parents and ancestors. Filial piety applies to the five bonds (relationships): ruler to minister, father to son, husband to wife, elder brother to younger brother and friend to friend. Confucianism, Taoism and Buddhism influence Chinese culture. One value of Confucianism is an emphasis on the importance of family, self-reliance, lifelong interdependence and faithfulness (Ran et al., 2005; Wong & Tsang, 2004). Chinese culture emphasizes harmonious personal relationships (Lam et al., 2010; Lin, 1983). Harmony interdependence and loyalty is key to survival, peace and happiness (Lin). Chinese familism is a system of cognitions, affects, intentions and behaviours focused on harmony, solidarity, family prosperity and sentiments (Lin et al., 1995). Many Chinese people have been influenced by these teachings of being group orientated, non-assertive and conflict avoidant (Wong & Tsang) and as such many Chinese behave and act in certain ways.

In Chinese culture, health is seen as related to harmoniousness influenced by a state of mind (Wang et al., 2009). In order to harmonize oneself with the social

environment, a person has to accept what happens in life and modify themselves to best fit in with it (Wang et al.).

Cultural issues influence detection of illness, utilization of mental health services and adherence (Mok, 2006). Values and beliefs held in Chinese culture could influence how some individuals encounter perceived stress, distress and motivation to access mental health services (Herrick & Brown, 1999). Individuals in Chinese culture may find it difficult to accept the notion of mental health disorders for various reasons. Some Chinese people perceive spirits and ghosts to be responsible for mental illness (Ran et al., 2005). There are some in the Chinese society that perceive people with psychosis to be cruel and prone to violence (Ran et al.) thus individuals are perceived as being dangerous. Having a mental illness often is seen as a punishment for the misbehaviours of ancestors or family's misconduct (Ran et al.).

Help Seeking Behaviours

The concept of balance and conservation influences Chinese perceptions of physical and mental health and illness (Lin et al., 1995). This conceptualization places an emphasis on the family as the basic unit of organization and basic resource for support (Lam et al., 2010) in resolving problems. It is common for Chinese individuals to use such informal networks for support (Wong, 2007).

There is a common coping pattern of help in Chinese families dealing with mental illness. Informal networks such as family and friends first observe behavioural or emotional problems (Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Wong, 2007). Often families cope with a family member affected with a mental health issue in the home for a long time before allowing trusted outsiders such as friends or elders to assist (Lin, 1983). It is the role of the family to act as an intermediary between affected

individual and mental health services (Ran et al., 2005; Wong, 2007). Constraining beliefs can prevent recognition of mental illness and prevents family members from seeking mental health options (MacLachlan, 2006; Ran et al., 2005) e.g., self and public stigma (Wong, 2007). Perceived discrimination is associated with more use of informal services (Spencer et al., 2010).

If families need additional support, they would allow outsiders e.g., herbalists, physicians or religious healers to treat the ill family member (Lin, 1983; Spencer et al., 2010). It is not uncommon for Chinese people to use multiple treatment approaches for mental health issues such as Western medicine, traditional Chinese medicine and folk therapy (Song et al., 2005; Ta, Holck, & Gee, 2010). Traditional Chinese medicine is a medicinal practice influenced by Confucianism and Taoism and addresses ailments as life-energy (qi) imbalances (Yang, Corsini-Munt, Link, & Phelan, 2009) through herbal drugs and acupuncture. Unlike Western medicine, traditional Chinese medicine does not dichotomize illness as physical and psychiatric as it treats health in a holistic manner (Yang, Phelan, & Link, 2008). There are beliefs that using traditional Chinese medicine is more effective than Western practices in treating mental illness (Yang et al.).

Somatization is a form of help seeking behaviour for psychological problems (Lam, 1995; Wong & Tsang, 2004; Ran et al., 2005) as a bodily disorder that is commonly seen in Chinese individuals. Somatization enables physical symptoms to describe emotions. It is a way to deny or suppress emotions to express affective states and lack differentiation between mind and body (Lin et al., 1995). It is common in Chinese culture for individuals to express their emotions in a somatic fashion as it is a core value to avoid extreme emotional reactions (Lam et al., 2010). In traditional Chinese medicine,

everything is interconnected and strong emotions can make people ill. In Chinese culture, sharing emotional feelings is a cause of shame as suppression of emotions is encouraged. As well, it is less stigmatizing for individuals to express themselves in a somatic fashion (Hsu et al., 2008).

Stigma

Stigma is defined as a “special discrepancy between virtual and actual social identity, and an attribute deeply discrediting but seen as language of relationships” (Goffman, 1963). Goffman (1963) observed that stigma could be seen as a relationship between an “attribute and a stereotype” to produce a definition of stigma as a “mark” (attribute) that links a person to undesirable characteristics (stereotypes). Link & Phelan (2001) conceptualized a model of stigma in response to the criticism of Goffman’s (1963) stigma concept being too vaguely defined and individually focused. Link and Phelan (2001) also further expanded on Goffman’s observation of stigma being seen as the relationship between an “attribute and a stereotype.” Their conceptualization of stigma includes: i) labeling, ii) stereotyping, iii) separation, and iv) status loss and discrimination occur together in a power situation that allows them (Link & Phelan, 2001). With labeling, people distinguish and label human differences (Link & Phelan) such as saying someone is depressed. Stereotyping occurs when dominant cultural beliefs link labeled persons to undesirable characteristics that form the negative stereotypes (Link & Phelan). An example would be the thought of every individual with depression is seen as ‘weak.’ According to Link and Phelan the separation occurs when labeled persons are placed in distinct categories where there is a degree of separation of “us” from “them” (Link & Phelan) – a method of distancing the “other” who has the mental illness. Status

loss and discrimination occur when labeled persons experience status loss and discrimination leading to unequal consequences (Link & Phelan) such as someone being turned down for a job because of having a mental illness. Status loss is connected to undesirable characteristics that reduce one's status in the eyes of the stigmatizer (Link & Phelan).

There are three levels of discrimination as described by Link and Phelan (2001). Individual discrimination is perceived as person 'A' labeling and stereotyping person 'B,' which leads person 'A' to engage in discrimination towards person 'B' e.g., person 'B' may be rejected for a job (Link & Phelan). Structural discrimination refers to accumulated institutional practices that work to the disadvantage of stigmatized groups (Link & Phelan). Status loss as a source of discrimination occurs when one's lower status is the basis of discrimination (Link & Phelan).

Stigma and Individuals with a Mental Illness

According to Scheffer (2003), stigma not only causes one to feel shame but also is layered upon racism, or as some note (Fernando, 2006), may "intersect" with racism. Goffman (1963) saw stigma operating with mental illness in a number of ways, for example, individuals with a mental illness may be perceived as having "blemishes of individual character," (p. 4) and/or as having treacherous and rigid beliefs towards others and as a consequence are treated differently. According to several authors, stigma operates when individuals with mental illness are devalued and/or fear is experienced. Often they are excluded because they are perceived to be less trustworthy, irresponsible or dangerous (e.g., Hsu et al., 2008; Link & Phelan, 2001; Link, Struening, Neese-Too, Asmuseen, & Phelan, 2001; Rüsçh, Angermeyer, & Corrigan, 2005; Yang et al., 2007).

Individuals with mental illness encounter misunderstandings within society regarding mental illness resulting in stigma. They then may accept the common prejudices about mental illness, turn against themselves and lose self-confidence (Rüsch, et al., 2005), a kind of internalized stigma so that when in situations with others they may perceive stigma when it does not in fact exist. Perceived stigma and discrimination may intersect with other barriers to treatment (Spencer et al., 2010) and could cause treatment delay or result in unwillingness to access mental health services.

Stigma and Chinese Culture

Stigma related to mental illness for some communities may be detrimental due to myths related to cause and treatment alternatives, somatization, shame and avoidance of seeking help (Scheffer, 2003; Ta et al., 2010). Cultural beliefs influence the severity of stigma (Hsu et al., 2008). In Chinese society, stigma is severe due to the collectivistic nature of Chinese culture (Fung et al., 2010). There is the presence of stigma related to mental illness within many ethnocultural communities including the Chinese community (Lo & Chung, 2005). Stigma related to mental illness is influential in Chinese culture. 'Face' represents a person's moral status in local community (Yang et al., 2007) in Chinese culture. When a person has loss of face by something such as having a mental illness, one is humiliated and unable to face others (Spencer et al., 2010; Yang et al., 2007). Families of Chinese individuals who have a mental illness can experience loss of face and can have their social standing jeopardized (Yang et al., 2008) as stigma moves from the affected individual to their family (Yang et al., 2007). Loss of face is attributed to different types of stigma by Chinese individuals. There are three levels of stigma: structural, public and internalized/self-stigma. Structural stigma refers to institutional policies, rules and practices of public and private entities of positions of power that create

inequality by restricting opportunities for people with mental illness (Livingston & Boyd, 2010; Michalak et al., 2011). An example is people who have been brought by police to the hospital to get assistance for their mental health. As a result, on their criminal record check, there is a box ticked next to having contact with police though there is no criminal record. When the individual applies for volunteer work or employment and a criminal record check is required, the individual could be rejected for volunteer opportunity or employment. This would have been the result from having contact with the police and possibly explaining why it occurred in the first place to the organization that the application is with.

Public stigma is comprised of the reaction of the general public towards a group based on stigma about that group (Livingston & Boyd, 2010; Rüsçh et al., 2005) such as individuals with a mental illness. Society could place negative beliefs on an individual e.g., being dangerous, and uncontrollable (Lam et al., 2010). Public stigma can threaten vital connections from an affected individual to their social network of support (Yang et al., 2007). For example, in Chinese society, stigma occurs when family members of an individual with a mental illness experiences 'loss of face.' This is due to etiological beliefs about mental illness that assign moral effect to sufferers and family members (Yang et al.). Relatives of an affected family member may experience levels of family stigma by the public (Lam et al., 2010). Shame engulfs each family member, including the affected individual, who could be ostracized from social networks, and experience reduced social status (Yang et al.). Families may be isolated by the stigma due to its burden (Lam et al.).

Self-stigma is a subjective process characterized by internalizing negative feelings about one's self. Maladaptive behaviour and stereotype endorsement can result from an individual's experiences or anticipation of negative social reactions on basis of their illness (Michalak et al., 2010). Self-stigma is how an individual belonging to a stigmatized group turns the stigmatizing attitudes and prejudice against themselves (Livingston & Boyd, 2010; Rüsç et al., 2005). Individuals internalize and accept the stigma as being justified (Lam et al., 2010). In addition with self-stigma, individuals agree with the stereotype and self-prejudice leads to having negative emotional reactions (Rüsç et al.) about themselves. This could lead to anticipation of social rejection (Livingston & Boyd). Importantly, as a consequence, self-stigma may result in an avoidance of mental health services to avoid possible sources of public stigma (Fung et al., 2010).

People of Chinese culture experience forms of prejudice towards mental illness (Song et al., 2005). This can affect their access to services as it increases reluctance to seek professional help (Lam et al., 2010) due to stigma. This is influenced by the three levels of stigma: structural, public and self. Stigma sometimes intersects with other forms of oppression, such as racism, to act as a barrier to access to treatment (Lam et al., 2010).

Access and Research in Canada with Chinese Populations

Research conducted in Canada with the Chinese population who access mental health services have focused primarily on those aged 65 years and older and immigrants. In most cases, the Chinese population was being studied because they are the largest visible minority group in Canada.

Older Adults

For Chinese people aged 65 years and older in Canada, problems of communication have been shown to affect access and service delivery (Sadavoy, Meier & Ong, 2004). Service barriers identified were administrative problems in service delivery, cultural incompatibility, personal attitude and circumstantial challenges (Lai & Chau, 2007). Lai & Chau (2007) found the difference between health service delivery in Chinese older adults' home country and in Canada is the lack of knowledge of existing health care services. This affects access to mental health services. Sadavoy et al. (2004) found that ethnoracial seniors were aware of community-based organizations through word of mouth but not mainstream services.

Access barriers to mental health services for Chinese older adults included clinicians who do not speak the same language or understand the culture, long waitlists, a lack of knowledge regarding specialized services and programs for the Chinese population, a lack of linguistically and culturally appropriate services and a perceived ineffectiveness of services (Lai & Chau, 2007; Li & Browne, 2000; Mok, 2006; Sadavoy et al., 2004). It was not uncommon for Chinese older adults to visit their general practitioners with physical or somatic complaints (Lai & Chau) as an access point for mental health issues.

Referral barriers impede access to mental health services as Chinese older adults often rely on their family to recognize emotional needs and distress and accompany them to who need to care (Sadavoy et al., 2004). The reluctance of Chinese seniors and their family to acknowledge and disclose problems (Sadavoy et al.) is a barrier to accessing mental health services. This is largely due to avoiding help because of shame associated

with seeking help, stigma and filial piety (Sadavoy et al.). These in combination or alone can lead to delays in seeking help.

Research conducted by Lai and Chau (2007) and Lo and Chung (2005) found that Chinese older adults felt unwelcome and uncomfortable accessing mental health services. There was a negative perception of health care providers, which included service and quality (Lai & Chau) that leads to Chinese older adults to think that providers are disrespectful and not helpful. Hence they were, uncomfortable and felt unwelcome to approach the health care system (Lai & Chau). In addition, Chinese older adults felt there was discrimination based on their age and ethnicity, a perception that underpinned their reluctance to access mental health services (Lai & Chau, 2007; Li & Browne, 2000).

Chinese older adults felt it was important for health care providers to use interpreters, be committed to confidentiality, understand mental health issues and not be judgmental (Lai & Chau, 2007). As well, Chinese older adults felt it was imperative for health care providers assisting with their mental health to be respectful, empathetic and be willing to talk about emotional problems and their awareness of mental health problem(s) (Sadavoy et al., 2004).

Adults

There has been little research conducted on Chinese adults and access to mental health services in Canada. Mok (2006) examined anxiety from a cross-cultural perspective in British Columbia for Chinese adults. Access barriers to mental health services found were language, waitlist, lack of knowledge of services, programs not specialized for Chinese users and professionals not familiar with Chinese culture (Mok). Mok (2006) also found that the language used to express emotional distress of anxiety was somatic. In addition, family and community supports and some use of traditional

Chinese medicine had been used by the time a Chinese individual had accessed formal mental health services (Mok).

Simich, Maiter, Moorlag, & Ochocka (2009) examined ethnolinguistic community perspectives on mental health. They found that lack of knowledge of services, distrust of services and language were barriers to help seeking (Simich et al.). Tiwari & Wang (2006) studied mental health and substance use by different ethnic groups in Canada. Asians were more likely to have mental health problems in North America compared to their home countries due to language, employment and acculturation issues (Tiwari & Wang).

Immigrants

Chinese immigrants' utilization of mental health services in Canada and determinants of mental health consultation has been researched (Chen & Kazanjian, 2005; Chen, Kazanjian & Wong, 2009; Chen, Kazanjian, Wong & Goldner, 2010; Tiwari & Wang, 2008). According to Chen & Kazanjian (2005), Chinese immigrant women had higher rates of mental health visits compared to males primarily through general practitioners. However, visits to a physician or psychiatrist for consultation or treatment with regards to a mental health issue were lower among the Chinese immigrant population in general (Chen & Kazanjian, 2009) compared to a control group of non-Chinese with similar demographics. Interestingly, Chinese immigrants who saw physicians with the same language (Chinese) were less likely to receive mental health services than those who did not visit Chinese-speaking physicians (Chen & Kazanjian, 2009). Disparities in utilization raise concern there may be inequalities in accessing mental health services for Chinese immigrants (Chen et al., 2009; Tiwari & Wang, 2008)

because Chinese immigrants were less likely to use mental health services as a whole than non-Chinese individuals.

There were various barriers Chinese immigrants experienced with access of mental health services. Chen & Kazanjian (2009) found pervasive underdiagnosis and undertreatment by health care providers to be a form of systemic barrier to mental health care. Culture, immigrant effect, stigma and language were major barriers to seeking help (Chen & Kazanjian 2005; Chen & Kazanjian 2009; Chen et al., 2010, Tiwari & Wang, 2008) in primary health care settings. Factors associated with the use of mental health services contribute to an understanding of migration, language, culture and mental health needs in help-seeking behaviour of ethnic Chinese population in Canada (Chen et al., 2009). Poor knowledge of mental health services and cultural understandings were barriers to accessing mental health services (Tiwari & Wang).

Immigrant Chinese Women

Wong & Tsang (2004) examined Chinese immigrant women's understanding of mental health. Wong & Tsang (2004) found that for the women, mental health was defined in relation to a woman being involved in socially defined roles and managing tension between her personal needs, imposed ideas and the external social demand, finding the balance between her own strivings and self-imposed ideals.

Tang, Oatley, & Toner (2007) examined the difficulties and life events that had an impact on the mental health of immigrant Chinese women in Toronto. They found gender differences in the rate of depression and psychological distress, which was related to the difference in exposure to stressful events between women and men, i.e., that women reported more of these events (Tang et al.) than men. Chinese immigrant women's mental health was impacted by familial relationships. A strong cohesive family was highly

valued. However, Chinese women who have recently immigrated to Canada often do not have extended family living close by. This impacted their mental health by contributing to their psychological distress.

Fung and Wong (2007) and Wong and Tsang (2004) studied Chinese immigrant women in Toronto, Ontario. Wong and Tsang (2004) found there was an existence of tension between social conformity and personal autonomy and self-direction – a central issue in accessing mental health services. Women dealt with situations encountered by conforming to socially established norms and moral conventions adopted by the majority of people (Wong & Tsang) such as moral codes and behaviour propriety. In addition, women stayed mentally healthy by observing social rules and ethics of their culture as part of focusing on self-development (Wong & Tsang). Fung and Wong found that differences in causal beliefs may influence women's attitudes toward seeking professional help e.g., if help was deemed valuable, then mainstream mental health services were sought. In addition, Fung and Wong (2007) found that Chinese immigrant women were perceived to have less of an ability to access culturally, gender and linguistically appropriate services than other Asian immigrants. Wong & Tsang (2004) also found there is more emphasis on social harmony for women compared to men, which tends to keep women in disadvantaged positions.

According to Wong and Tsang (2004) this emphasis on social harmony stems from Confucianism where the philosophical beliefs are focused on human morality and right action such as filial piety. This emphasis on filial piety in Chinese culture is highly influential. Principles associated with Confucianism can affect the alliance and power in relationships, which can then affect the relationships between Chinese women and health

care providers – another way in which women might experience disadvantage and as a consequence be less likely to access services.

Tang and Tang (2001) examined Chinese women's mental health in relation to gender role internalization in Hong Kong. This was to study its role as a moderator in the relationship between women's multiple roles and psychological distress. They found role quality was more important to Chinese women's mental health and well-being than role quantity. Work role had the largest impact on psychological distress for women (Tang & Tang).

Chiu (2004) found in Hong Kong, that women were more likely to seek help for psychological problems than men. However, women tended to distance themselves from formal helping networks because of the consequence of help seeking except in desperate circumstances (Chiu). Women tended to be more self-reliant and sought family and friends or assistance for psychological issues and help seeking was seen as a violation of self-reliance (Chiu). According to Wynaden et al. (2004) Asians do not readily seek help from mainstream mental health services.

Tang and Tang (2001) found mental health concerns are more prevalent in Chinese women than men. Chinese women's mental health is affected by their work role, which includes duties and responsibilities and quality- beliefs of being able to self-sacrifice and being the traditional ideal person (Tang & Tang). Being able to self-sacrifice refers to women giving up things in their life for others. The 'traditional ideal person' refers to the beliefs held regarding the role of Chinese women from a cultural perspective. In their study, Tang and Tang found that for Chinese women who had a high endorsement of a 'traditional ideal person,' that this was a main factor of their anxiety,

depression, social dysfunction and somatic symptoms (Tang & Tang). Women experience stress and difficulties in fulfilling multiple roles that affect their mental health (Tang & Tang). As well, in traditional Asian society, cultural expectations embody deference, and acceptance of suffering and personal sacrifice, which may be magnified for women (Tang et al., 2007). Tang and Tang found that a higher endorsement of the 'traditional ideal person' negatively affects the mental health of Chinese women. The women displayed these traits through symptoms of anxiety, dysfunction and somatic symptoms (Tang & Tang). Women who sacrifice a lot are more distressed when their quality of work role is high. Lastly, according to O'Brien (2002) Asian women, including those who are Chinese, underutilize mental health services as their cultural religious beliefs are seldom recognized in planning and delivery of psychiatric community support services.

Gaps in Literature

There is a need to create a system of mental health services that is available, accessible and acceptable to all (Ganesan & Janze, 2005). Ganesan and Janze note that mental health services need to be culturally appropriate and responsive and note the need for equity in access for anyone regardless of background. Mental health is plagued by disparities in availability and accessibility to services (Drake et al., 2005). People of ethnic minority background in Western countries face more service barriers (Lai & Chau, 2007) than those persons from dominant culture groups. The 1971 multiculturalism policy in the Canadian Charter of Rights and Freedoms (Citizenship and Immigration Canada, 2008) has not led to 'equal' access to health services for Asian communities (Lo & Chung, 2005) compared to other populations. This has resulted from a lack of mental

health planning nationally and provincially, systemic neglect of less-vocal populations and discouragement from focusing on any particular group for mental health services (Lo & Chung). According to Ganesan and Janze (2005) services underpinned by a multicultural health ethic should reflect racially, culturally sensitive, responsive and acceptable care for all populations within community with the overriding principle being ‘health equity’³ in terms of access for all persons.

There is little research available in Canada that examines mental health and the general adult Chinese population, particularly gender effects. Search terms used to search databases for research articles in various combinations were: Chinese, mental health, help, service, Canada, women, psychological, emotional, utilization, access, primary health and barriers. Only a handful of relevant articles were found. There is much more research focusing on the Chinese adult population and mental health in the United States. Its focus is primarily on the underutilization of mental health services (Herrick & Brown, 1999), practical barriers to seeking treatment (Kung, 2004) and the cultural beliefs of some individuals. In Canada, there is little research being done to examine gendered effects of being Chinese and access of mental health services. There is little known about determinants or factors related to the Chinese immigrants and older adults’ use of mental health services. There are some indirect assess points for determining mental health requirements. For immigrants, who go to general practitioners speaking the same language was found to be less likely to receive mental health services (Chen & Kazanjian, 2009). Community based agencies with ethno-specific workers are another access point for people seeking mental health services. They are perceived to be most

³‘Health Equity’ is the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically (World Health Organization as cited in Health Officers Council of BC, 2008).

accessible and served as a point of identifying psychiatric problems and entry to mental health services (Sadavoy et al., 2004). For adults aged 65 years and older and immigrants, the use of ethno-specific workers from community based organizations helped to facilitate awareness and access of mental health services (Lo & Chung, 2005; Sadavoy et al., 2004).

Studies of cultural diversity and mental health have emphasized dimensions of culture or power but not integrating them or looking at their relationship (Simich et al., 2009). Research into mental health services helps to illuminate conditions and circumstances in which individuals recognize problems and seek help as well as understanding effectiveness of help delivered (Drake et al., 2005). Exploring access is necessary to assist in understanding how to improve access to culturally appropriate mental health services (Chen et al., 2009).

Summary

It is known that for the Chinese population in Canada, cultural values such as filial piety, role of family, somatization as well as stigma can affect one's access to mental health services. Chinese older adults and Chinese immigrant women in Canada experience barriers affecting access to mental health services. Such barriers are language (Chen & Kazanjian, 2005; Chen et al., 2010; Mok, 2006; Sadavoy et al., 2004), personal attitudes towards help seeking and mental health services (Lai & Chau, 2007; Tiwari & Wang, 2008), long waitlists (Lai & Chau, 2007; Mok, 2006; Sadavoy et al., 2004), culture (Chen & Kazanjian, 2005; Fung & Wong, 2007; Wong & Tsang, 2004), inappropriate services in terms of language and cultural competence, (Lai & Chau, 2007; Lo & Chung, 2005; Mok, 2006), and lack of knowledge of mental health services (Lai &

Chau, 2007; Mok, 2006; Sadavoy et al., 2004; Simich et al., 2009; Tiwari & Wang, 2008). For Chinese women, gender and work role has an affect on their mental health.

At present, it is unknown what facilitates or deters Chinese women who are not new immigrants or older adults from accessing mental health services in Canada. This warrants research to be conducted for this population group.

In Chapter Three, I will discuss the rationale of using interpretive description for this study. I will discuss sampling, recruitment of participants, ethics, and data collection. As well, I will discuss data analysis and rigor.

CHAPTER THREE: METHODOLOGY

Introduction

In this chapter, I will describe the methodology and methods. Before discussing the methodology, I will situate myself as the researcher. I am a first generation Chinese woman born in Canada. I bring different perspectives as the researcher as my views have been influenced by my upbringing and Chinese culture. I do not follow all traditional Chinese rituals due to the influence of growing up in Canada. As well, I am a Registered Nurse and have worked in mental health for the past eight years. It is the clinical area where I began practice post graduation and have a passion in helping others in this field. The last five years, I have been working in community mental health.

Methodology

The research question posed in this study is: What are Chinese women's experiences of access to mental health service? To answer this question, I employed a descriptive, qualitative study that used in-depth interviews to examine Chinese women's experiences – an appropriate fit with this question. Interpretive description, a non-categorical method of research (Thorne et al., 1997) helped to create a context of engagement with data, including assumed knowledge to explore this topic (Thorne, 2008). Thorne et al. (1997) used methods in keeping with interpretive description as a means to assist nurses to develop knowledge about Chinese women's experiences to inform what constitutes barriers/challenges and facilitators to access.

In keeping with the approach/methods described by Thorne (2008), interpretive description methods assisted me to generate new insights with application to practice. Interpretive description framed ways of seeking knowledge through data collection

methods such as in-depth individual interviews to inquire in a respectful manner and in a manner consistent with ethical research guidelines and foundations of ethical clinical practice (Thorne).

Through interpretive description I captured themes and patterns from subjective data with the goal of providing clinical understanding of ideas and concepts (Thorne et al., 2004; Thorne, 2008). I used knowledge through in-depth interviews with research participants and generated common patterns found within life experiences of the participants (Thorne et al., 1997), which were relevant to this study. Using the interpretative description method to analyze data helped to move beyond participants' descriptions to engage in interpreting participants' experiences from their perspectives (Thorne et al., 1997). Interpretive description is appropriate to use for in a study with a small sample; this to capture themes and patterns within subjective perceptions to generate understandings capable of informing clinical practice through interviews (Thorne et al. 2004). This analytic method assists in synthesizing meanings and theorizes relationships through recontextualizing data into findings (Thorne et al., 2004). In this study Chinese women's experiences formed meanings and relationships between themes.

Individual in-depth interviews were used as a way of getting first hand knowledge of Chinese women's experiences through gaining access to their subjective knowledge (Thorne, 2008). Interviews are useful for development of knowledge in relation to many of the clinical issues we encounter (Thorne) such as access of mental health services. Interviews contain contextual and background information of significance from the perspective of the study participant(s) (Thorne). For this research study, individual in-depth interviews were used to collect data and will be discussed later in this chapter.

Before any research was conducted in clinical settings, ethics applications were approved by the Research Ethics Board at the University of British Columbia and Vancouver Coastal Health Research Institute.

Sampling

Interpretive description requires purposeful selection of research participants whose accounts reveal elements that are to some degree shared by others (Thorne et al., 1997); this to assist in generating knowledge to inform nursing practice. In this study, I used purposive sampling techniques in several mental health settings. Individuals within these settings were recruited with the knowledge that they could provide an angle of experience in relation to the research questions (Thorne, 2008). In this study, Chinese women with mental illness were sought to examine their experiences accessing mental health services. According to Thorne et al. with purposive sampling, participants are selected according to the needs of the research study to allow for maximum variation in phenomenon studied. In this study, interviewing ended when I was satisfied that the question being asked had been answered. Sampling in qualitative research is an evolving process as data collection and analysis occur simultaneously and sampling needs can change; thus the strategies need to remain flexible (Milne & Orberle, 2005).

Inclusion criteria for study participants were: i) women of Chinese descent, ii) living with a mental illness, iii) who had lived in Canada for two years or more (could be Canadian-born), iv) were English speaking, and v) who were between the ages of 19-70 years of age. The interviews were designed to explore Chinese women's experiences of accessing mental health services in a way that, as Thorne (2008) would say, honours the inherent complexity of that experience.

In addition to Chinese women, I interviewed a small sample of non-Chinese women. During the analysis of the interviews with Chinese women, I made a decision to interview non-Chinese women to explore the ways in which the experiences described by Chinese women were unique and/or shared with non-Chinese women – part of a triangulation strategy. The inclusion criteria for non-Chinese women was that they i) were English speaking, ii) had lived in Canada for two years or more, iii) were between the ages of 19-70 years, and iv) were living with a mental illness.

Data triangulation promotes the validity of data findings by using various data sources (Speziale & Carpenter, 2007). This assists the researcher to seek a comprehensive understanding of a phenomenon (Rapport & Maggs, 1997). Data triangulation adds breath and depth to the findings through the use of different groups of people (Speziale & Carpenter). It is a common experience of field researchers for a phenomenon of interest to be far more interesting and complicated than initially anticipated (Thorne, 2008). For example, in this study I found that there were experiences of Chinese women that were somewhat different than for non-Chinese women but that the women also shared similar experiences such as the long waitlists that rendered access challenging.

In addition, to interviewing non-Chinese women I made a decision to interview health care providers working in mental health care settings. This aspect of the data triangulation process was engaged to provide another perspective regarding Chinese women's experiences of access to mental health services. As Thorne (2008) notes, key informants such as health care providers can provide access to what is happening and why. Two health care providers working in mental health settings with both Chinese and non-Chinese women were interviewed. The inclusion criteria for the health care providers

was that they were i) English speaking, ii) working within the mental health settings with both Chinese and non-Chinese speaking women, and iii) were 19 years or older. To summarize, three groups of participants were recruited for interviews using purposive sampling: Chinese women with a mental illness (n=7), non-Chinese women with a mental illness (n=2) and health care providers (n=2) working in one mental health care setting (total N=11 participants).

Recruitment of Participants

Being a Registered Nurse working in community mental health gave me familiarity with the health care system as well as a connection with potential participants. The study was promoted through my workplace and community agencies working with Chinese women. To ensure an arms length approach as a researcher, colleagues and community partners recruited potential participants, Chinese and non-Chinese women and health care providers. Anyone interested in participating in the study was instructed to contact the researcher (myself). Once I obtained the names of potential study participants who wished to be involved, I contacted them. I explained the research study and ascertained their interest to see if they wanted to participate so I could arrange a meeting. I met the potential study participants at a convenient time and location of their choice. In interpretive description, data is collected in a naturalistic context; the researcher is respectful of the comfort and ethical rights of participants (Thorne, 2008) – an approach I employed in this study.

I worked on building and maintaining trust during the initial meeting with potential study participants. I explained the purpose of the study and answered questions. I ensured the potential study participants were aware of risks that may be involved in

being interviewed. The risks of participating in an interview were the possibility of being tired of thinking or talking about their experiences or eliciting difficult feelings.

Individuals who agreed to participate in the study, were given an informed consent form (Appendix A) to sign before the interview could begin. All participants were given a copy of the consent form and informed regarding the use of a digital recorder for the interviews. They were assured that their names would not be used and confidentiality would be maintained.

Characteristics of Participants

There were seven Chinese women recruited for the research study, ages ranging from 28 to 57 years. Two participants were born in Canada. They all spoke English, had lived in Canada for at least two years, and had a mental illness. The diagnoses included Bipolar disorder, Depression with Psychotic features, Schizoaffective disorder, and Schizophrenia (Appendix B). Some women were receiving care and some were not, but they all had a mental illness. They all wanted to participate in the study to help to improve mental health services for other people.

Two non-Chinese women were recruited (55 and 60 years old respectively). The women spoke in English and had lived in Canada for at least two years. Both women had a diagnosis of Bipolar disorder, Type I. Two Registered Nurses working in mental health settings were interviewed, one had worked four years and the other had thirteen years experience in mental health.

Ethics

I submitted ethics applications to the Research Ethics Board at the University of British Columbia and Vancouver Coastal Health Research Institute, which were

approved. An amendment for the ethics approval was sought through the Research Ethics Board at University of British Columbia so non-Chinese women and health care providers could be recruited and interviewed.

My employer requested that study participants, who were receiving care at my worksite, be interviewed at another location. I ensured participants I interviewed were not my clients from my workplace. The rationale was so they would be less likely to feel coerced or feel their care would be affected by participating in the study. I could remain at arms length from my role as a Registered Nurse in this setting. This assisted me in maintaining my role as researcher rather than provider in the context of this study. My team leader was asked to recruit health providers for the study, again, to ensure that none of the potential participants felt coerced to be involved.

I ensured participants were provided informed consent before participating in the study. Written consent was obtained from each participant and they were aware they could withdraw anytime during the study. I was unable to do a second interview with some participants as they declined or were not feeling well.

Participants were informed that committee members and I would have access to the data. Pseudonyms were used instead of names in the transcripts for purposes of confidentiality. As well, names of participants were not used in the interviews.

Data Collection Methods and Procedures

The interviews took place in a location and time of the participant's choice. In person one to one interviews can help to establish strong rapport with generally hard to access study participants to discuss personal topics (Morse & Field, 1995). As noted above, before the interviews began, consent was reviewed and questions were answered.

I shared my professional background and rationale for doing the study. According to Thorne (2008) this helps to situate self within the research role by disclosing the nursing discipline and portraying self to the participants (Thorne). Participants were assured that their identity would be kept confidential and not used in the interviews, which was important to them. Most of the Chinese women participants wanted to know what organizational changes could be made in the future so Chinese women could have better access to mental health services. I told the women that based on the findings of the study, recommendations could be made for clinical practice, education, research and policy.

The interviews were conducted in English and were digitally recorded. I began the interviews with open-ended questions (Appendix C). During the interviews, I listened intently to the participants while minimizing interruptions. As recommended by Morse and Field (1995) I tried to avoid the use of close-ended questions. I would reword questions if they were not understood initially.

I would take field notes during the interviews on interactions as well as notes on my self-reflections. Field notes can be used to reflect sensitivities, meanings and understandings (Morse & Field, 1995) and to assist in reducing bias. The interviews were between 15 to 45 minutes in length. Sometimes after the interview was conducted, the participants and I would have more discussion because the interviewees often felt more comfortable talking without being recorded. This was particularly evident in my interviews with Chinese women. I would make field notes to capture as much breadth of the content being discussed.

After each interview, I made field notes to write insights and interactions during each experience. As Thorne (2008) recommends, field notes provide a means of writing

down the researcher's first impressions and help to track the inductive process. Morse and Field (1995) note that field notes help to identify relationships within data. In keeping with the perspective of Thorne (2008), in this study, field notes assisted in helping me to remain mindful of the personal influence that I could have on data sources throughout study. Field notes also enabled me to write down ideas or questions to be explored in future interviews.

A transcriptionist transcribed the interviews. The verbatim transcripts were password protected. I reviewed each interview by listening to the audio while reading the transcript to see if there were any differences. I would then re-read transcripts while listening to recordings of the interviews as a means of checking to ensure the data provided by participants was correct. This was to compare the transcripts with audio recordings to recall observations that took place during the interview e.g., physical body language and tone of voice. I employed Thorne's (1997) approach to interpretive description by being immersed with the data through listening to interviews and reading transcripts before coding. All field notes and recordings were kept in a secure place.

Interpretive description requires ongoing engagement with data (Thorne, 2008). I strategically employed ongoing engagement with the data through confirming, testing, exploring and expanding on conceptualizations that began to form as soon as I entered the field. As Thorne notes, interpretive description assumes the researcher is engaged in data analysis and data construction concurrently and that analysis informs ongoing data collection (Thorne). As Thorne recommends, I engaged in second interviews with some participants who were willing, to confirm, clarify and elaborate on essential relationships I began to observe within the data set.

Data Analysis

Data analysis is a process requiring astute questioning, a relentless search for answers, active observation and accurate recall (Morse, 1994). Data analysis helps to organize, provide structure to elicit meaning from research data (Polit & Beck, 2008). The goal of data analysis in interpretive description is to sort ideas fundamental to understanding the phenomenon in which the researcher has based the research question(s); what is common and what essentially is part of the story or question (Thorne, 2008). Interpretive description requires an analytic form beyond taking things apart and putting them together (Thorne). Data analysis requires making accurate records and spending time to immerse in records as well as to develop a sense of whole beyond an immediate impression of what it is they contain (Thorne). With inductive data analysis, multiple realities in data are identified and full settings are described (Lincoln & Guba, 1985).

As a novice researcher, I met with my supervisor to gain assistance regarding how to do the process of data analysis. I engaged with broad based coding where I would read each transcript line by line. According to Sandelowksi (1993) by reading transcripts, the researcher may provide additional data to be analyzed such as recalling details during the interviews. Interpretive description requires seeking a kind of knowledge that must be inductively generated from within data developed within the context of that data (Thorne, 2008).

In this study, I examined participant narratives in the context of an analytic framework. I would colour code words that stood out in each interview. As Thorne (2008) explains this is a means of flagging certain data elements as potentially

meaningful for various reasons. Similar to what Thorne notes, this was important for my final conceptualizations and to demonstrate how the data for one participant was different from the rest. I used the same colour to code words that commonly came up in the transcripts. Immersion in transcripts was enhanced by the act of writing down notes along the margin. This method was used to make note of the context of the words that stood out or to make comments on content that stood out.

Coding is a process that helps to sort data and uncover underlying meanings in text and metaphorical references (Morse, 1994). When coding line by line, I looked for what Morse terms ‘signs’⁴ that may have linkages to other concepts or contexts. Codes formulated are units of info that stand by themselves (Lincoln & Guba, 1985). This was a means to formulate broad-based codes, which as Thorne (2008) notes, are a collection of themes and ideas that could be thematically related and further interrogation. This led to assisting with open coding where, as Thorne discusses, data was fractured and examined into discrete parts for similarities and differences they revealed as they were organized into categories. According to Thorne, data elements become linked as you better appreciate the implications of their contextual meaning.

After I coded the interviews, I made a visual map with the various concepts that arose and showed they were related or separated from each other. This provided a visual method of seeing how conceptualizations could be formulated. I reviewed insights, ideas and conceptualizations that were recorded in a notebook. According to Morse (1994), the

⁴ ‘Signs’ is defined as an icon (dependent of relationship of the sign and what is signified), index (sign points to something else which indicates causality) and symbol (representing a relationship between sign and its presentation) (Morse, 1994).

researcher must remain cognizant of emic perspectives⁵ and how such data may contrast with etic perspectives which the researcher views (Morse, 1994). Note taking was a form of self-inquiry recommended by Thorne (2008) that provided me with an opportunity to see when I was in the role of learner versus that of clinician.

Interpretive description required synthesizing, theorizing and recontextualizing as part of data analysis (Thorne et al., 1997) using inductive analytic approaches (Thorne et al., 2004). In keeping with the methods outlined by Morse (1994), data analysis in this study involved comparison of transcripts from several participants and analysis of categories sorted by commonalities, elements of transcripts or notes from transcriptions of several participants. Several similar participant responses were merged to describe the process of the group (Morse) as part of synthesizing data. Content analysis was the most common form of analysis and involved systematical reduction of data into coded units that were clustered into categories according to shared characteristics (Milne & Oberle, 2005). According to Morse (1994) when synthesizing, the researcher becomes aware of certain points of juncture as significant and needs to explain variation in data. Potential generalizations are discovered in one case and are compared with another similar class until phenomenon can be tested against all similar cases (Morse).

As described by Morse (1994) I recontextualized data into findings by cross-referencing with the present literature. I consulted with my supervisor and committee members and asked them to review conceptualizations and provide input into an analytic framework that was developed. The committee helped me to critically reflect and use the findings as part of the data analysis. On their advice, I went back to some of the

⁵ 'Emic' perspectives are local (e.g., participant) while "etic" perspectives are external (e.g., often the researcher) (Morse, 1994).

participants to ask further questions for clarification about their responses as a means of cross referencing. I had to ask new questions that stemmed from the data analysis in order to obtain more data (member checking).

According to Sandelowski (1993) by going back to do a second interview with participants who agreed to do so, the researcher is enhancing rigor of qualitative work by specifying the set of auditable practices with the goal of representing the participant's point of view. According to Thorne (2008), member checking is a mechanism for confirmation, clarification, and elaboration on the essential relationships that is being suspected. I had to ask participants more questions and to clarify some responses to ensure that the participant's initial perspective was correctly represented so I could continue with the analysis of the data. I tried, as Thorne (2008) suggests, to be respectful to ensure participants in the study revealed what they were comfortable with and no more.

This study has an audit trail where one can see the development of how findings were created through data collection and data analysis. According to Morse (1994) an audit trail allows research validation by allowing another investigator to follow the cognitive development. A logical trail through which decisions pertaining to background resources have been constructed, build a case for, as Thorne (2008) notes "what is not known and what is worth knowing."

Rigor

Rigor is a reflection of the researcher's ability to stay close to the surface of the data while capturing all the elements of that experience (Milne & Oberle, 2005). Rigor can be obtained by using several approaches. With interpretive description, the researcher

is trying to use specific approaches to generate what he or she is attempting to achieve beyond the methodological precision and ethical accuracy (Thorne, 2008). For this research study, I used data triangulation, a journal to record thoughts during the research process and consistency in asking questions to participants as part of ensuring rigor. These methods will now be discussed further.

I spent a long time immersed with data, which helped to ensure rigor and trustworthiness acquired through data triangulation (Lincoln & Guba, 1985). In this study, triangulation involved interviews with Chinese women, non-Chinese women and health care providers to examine Chinese women's experiences of mental health services. Peer debriefing was done with my supervisor and committee members to validate the research process and results that emerged from data analysis. In keeping with the perspectives of Lincoln and Guba, trustworthiness was maintained by using a field journal to write down personal reflections, methodological points and day-to-day activities.

Credibility is the truth as experienced by study participants and interpreted from findings with co-participant evidence (Morse, 1994). Credibility is related to the study's purpose and what the study was intended to study (Milne & Oberle, 2005). In keeping with the work of Lincoln and Guba (1985), credibility was established in this study by using a journal to record thoughts and feelings after each transcript to recognize personal opinions that could have affected the research process. The use of triangulation improves probability of findings, and credibility of interpretations (Lincoln & Guba). In keeping with the work of Lincoln and Guba, I met with my supervisor for peer debriefing to help

me to be honest about personal biases, meanings explored in the study and to clarify the basis for interpretations.

Consistency in qualitative research is difficult given the variation in the personal experiences of the participants. In this study, I asked the same guiding questions to each participant. However, new questions were formulated during the interviews based on the responses of the participants. For example, some responses from participants needed more clarification or probing.

Dependability is a criterion met once researchers demonstrate credibility of findings through triangulation (Speziale & Carpenter, 2007), which was conducted in this research study. Confirmability is a measure of how well the inquiry's findings are supported by the data collected. (Lincoln & Guba, 1985). In keeping with the methods outlined by Speziale and Carpenter, confirmability was achieved in this study through the audit trail to illustrate evidence and thought process leading to conclusions and through the use of a personal journal.

With interpretive description, the researcher's background and experience is part of the inductive analytical process by making sure the research biases and beliefs are not in the results, only the participants. As a Registered Nurse with no history of mental illness I could not let any personal biases be part of the study. I reviewed my notebook for any biases. An audit trail was done to ensure rigor by consulting with committee members. I had to be aware and document personal contexts and biases throughout the data collection process. I had to constantly be aware of my role as a Registered Nurse and not let it conflict with being in the role of a researcher.

Limitations of the Study

There were several limitations with the research study. This was an exploratory study with a small sample size. Sampling was limited by the inclusion criteria. It was difficult to recruit Chinese women to speak about their experiences. The sample size may have been increased if I had included women who spoke only Cantonese and/or Mandarin and used a translator. As well, I realized while interviewing the Chinese and non-Chinese women that they needed insight into their mental illness to be able to talk about such experiences. Without this insight into their mental illness, they would not be able or be comfortable to discuss their past experiences with accessing mental health services or their health.

Summary

In this chapter I discussed the rationale for using interpretive description as the research method for this study. Study participants were recruited through purposive sampling. Ethics was discussed. Data was collected through individual in-depth interviews with Chinese and non-Chinese women who live with a mental illness and health care providers (Registered Nurses) working in a mental health setting and through field notes. Analysis of data and rigor were discussed in depth. In the fourth chapter, I go on to present and discuss the findings.

CHAPTER FOUR: FINDINGS AND DISCUSSION

Introduction

The use of participant individual in-depth interviews and field note recordings in this research helped yield five main overarching themes: 1) Stigma and Mental Illness; 2) Social Supports: Connections with Families and Friends and the Double Edged Sword; 3) Language and Access; 4) Lack of Coordinated, Seamless Care and the Intersection with Mental Health Literacy; and, 5) Health Care Providers and Peer Support: Navigating Mental Health Services. In addition, women's experiences of access to mental health services intersected with the structure of the health care system to shape/influence access and their experience of health and well-being.

It is important to note that in addition to the shared experiences as documented in the themes, the women in this study also had different stories to share about their experiences of mental health services – each experience being unique. The participants are to be seen as individuals with their own perspectives that have been shaped by their life experiences, acculturation histories, and gender, to name a few.

Stigma and Mental Illness

Stigma was a common theme across all of the interviews with both Chinese women and the health care providers. For Chinese women, stigma was a dominant factor. This affected their access to mental health services due to the perceived shame it brought on at an individual level but also for the Chinese women's families.

Self-stigma, as discussed in the review of literature, was commonly experienced by Chinese women largely due to the influence of what they deemed as 'Chinese culture.' The women experienced subjective negative feelings about themselves as a result of what

Michalak et al. (2010) describe as stereotype endorsement resulting from negative social reactions within their ethnocultural group. For the women in this study, having a mental illness meant they would be treated differently within their respective social community. Several women noted it was common within their ethnocultural group to hear negative comments related to individuals with a mental illness, e.g., being labeled without people taking time to get to know an individual. Link and Phelan (2001) describe labeling as when people distinguish and label human differences. This kind of experience is discussed by Chinese women participants in the following interview excerpts,

Once they know that oh you are going into those hospital or seeing psychiatrist, they kind of like feeling that you are a mental patient and they will be scared of you or staying away from you, so I guess it's hard for people, Chinese, like if they have problems they don't want to tell people. They just want to hide them and they were scared of being labeled crazy or abnormal and also Chinese culture is like people spread like... spread the information quite fast like because they like talking about people. Participant F

and

there's a stigma between mental illness, I think there probably... there would be more people that need help, but they don't understand and they don't like the stigma behind it being able to go find help from a team or whatever, but umm I think because of the being a Chinese background, it's... I find people don't accept you as a person with a mental illness. Participant G

and

A lot of Chinese look at their own kind with tainted eyes. They don't understand the condition, so they're afraid... they see others that have the condition with a different type of... they act differently, they talk differently or they don't associate with you once they figure out or find out that you have that condition. So a lot of the Chinese women or Chinese people in general, they don't ask for help because they don't want to be known that they have the condition and you know have to be treated differently. Participant A

These participants experienced, what Goffman (1993) might refer to as “blemishes of individual character,” (p. 4) which is consistent with self-stigma – negative stereotypes

that Link and Phelan (2001) say are tied to dominant culture beliefs (public stigma) that link labeled persons (in this case people with mental illness) to undesirable characteristics. The experiences of the participants are similar to what is noted in the existing literature where individuals with mental illness are devalued and experience fear and exclusion as a consequence of living with a mental illness (Hsu et al., 2008; Link & Phelan, 2001; Link et al., 2001; Rüsçh et al., 2005; Yang et al., 2007).

Public stigma is comprised of the reaction of the general public towards a group based on stigma about that group (Livingston & Boyd, 2010; Rüsçh et al., 2005) such as individuals with a mental illness. This was evident in the participant interviews as public stigma threatened, what Yang et al., (2007) referred to as, vital connections from an affected individual to their social network of support such as family.

‘Loss of face’ was a contributing factor to self-stigma for Chinese women; this associated with the individual’s perceived loss of moral status in local community. In this study, the women’s experience of ‘loss of face’ was associated with public stigma emanated from within their particular ethnocultural group – an experience that was internalized (self-stigma). For many Chinese, stigma occurs when family members of an individual with a mental illness experiences ‘loss of face’ as they are humiliated and unable to face others (Spencer et al., 2010; Yang et al., 2007). This is due to etiological beliefs about mental illness that assign mental illness as a moral effect to sufferers and family members (Yang et al.). Many of the families of the women in this study experienced shame due to living with a mental illness. In the following examples Chinese participants discuss their perspectives on ‘loss of face’ and stigma,

because as a whole it’s something that my family is very ashamed, you don’t talk about it and I still see that when I hear some of the friends and family talk

depending... so as a whole I'd say that stigma is more within the Chinese community. Participant A

and

because Chinese culture and I think Western is different and then... I think as a Chinese who got mental illness, it's a shame and the family is like, they don't want to talk about it, they just pretend ignore it. Participant D

Generally the Chinese participants in this study did not want people in their communities to know they had a mental illness unless it was immediate family members and close friends. This, in keeping with the findings of Chiu (2004), who noted that individuals with mental illness are concerned privacy could be breached within their community with consequences for how they and their family might be treated.

The participants in this study clearly illustrated the effect stigma had on them – self-stigma and public stigma, which included family, friends and society. In addition, for the women in this study, there was a common experience of shame with having a mental illness even if they had supportive family and friends.

Health care providers verified the role stigma played in access to mental health services. They were aware of the shame experienced by people living with mental illness and their families as noted in the following example,

Personal stigma, not being to overcome...personal acceptance of the stigma, not actually getting treatment at the time. Participant K

and

I think it's most important to be aware of the still existent stigma within the culture about mental illness and how you work around that and work with the families with education. There is a very strong stigma against mental illness in Chinese culture and a huge sense of shame in letting others know. Participant J

Hence, health care providers had to be aware of the shame that surrounds living with a mental illness and the associated reluctance to seek help when engaging with Chinese

women accessing the health care system. This awareness was important in the provision of health care, health education.

The stigma associated with mental illness took on a somewhat different form for the non Chinese women who were interviewed. The non Chinese women experienced a general lack of understanding by society (public stigma) about having a mental illness.

One participant discusses this in the following excerpt,

A lack of understanding that ...that umm you could be depressed for no reason; that all of sudden you could feel depressed and it was nice day, why were you depressed and cheer up. Participant H

This kind of stigma is pervasive in our society and as such a target of the national anti-stigma campaign of the relatively recent Mental Health Commission of Canada (2009).

Another non Chinese woman describes her experiences of having a mental health diagnosis in the following,

we would go to the pub and you would hear whispers-oh, she's got a mental illness, oh she's crazy, oh she's loony tunes. You have to just uh...sometimes you have to just let it roll off your shoulders right, because it's always going to be there to some extent. Participant I

Most participants in this study expressed the hope that by participating in the interviews, women's access to mental health services would be improved. As well, they hoped improved access would diminish the stigma associated with mental illness, i.e., living with a mental illness would be more normalized.

Although all of the women in this study experienced stigma there was a subtle difference in the experience of stigma between Chinese women and non Chinese women. The Chinese women noted that stigma was associated with stigma that emanated from within their ethnocultural group and was then internalized (self-stigma)– stigma that was strongly associated with the idea that the family would 'lose face' with the consequence

of deterring them and others they knew from seeking help. For non Chinese women, although their source of the experience of stigma was also societal (public) and also internalized, the experience occurred post mental health access and was directly related to being *diagnosed* with a mental illness and associated lack of understanding related to mental illness in society.

Social Supports: Connections with Family and Friends and the ‘Double Edged Sword’

In Chinese traditions, the family is regarded as the fundamental unit of society (Lam et al., 2010) and source of strength in times of adversity such as being diagnosed and living with a mental illness (Tse et al., 2010). It is common for Chinese individuals to use such informal networks for support (Wong, 2007) such as family and friends – also a finding in this study. This is influenced by philosophical constructs and cultural values. Principles of Confucianism such as filial piety, cultivation of harmony within self, emphasis of harmonious personal relationships and centrality of family (Jim & Pistrang, 2007; Tsang et al., 2003; Wong & Tsang, 2004) was prominent in the study.

However, the use of mental health services might be inhibited depending on how the families/friends perceive mental illness and health (Akutsu et al., 2007). Constraining beliefs can prevent recognition of mental illness and prevent family members from seeking mental health options (MacLachlan, 2006; Ran et al., 2005) e.g., self and public stigma (Wong, 2007). Seeking professional help may affirm failure and put self and family at risk of being rejected in the community (Chen et al., 2009) due to the stigma of mental illness that often exists there. In addition, mental illness may be considered a threat to the balance of harmony of family relationships because of shame associated with mental illness (Tse et al., 2010). The stigma associated with mental illness can be a major

barrier to access of mental health services and families may want to protect their family members and themselves as a result.

In this study, on the one hand, family was perceived by most of the Chinese women as a major source of support and, on the other, the women felt shame and fear associated with family knowledge of their illness – creating a kind of ‘double edged sword’ for the women as they sought support. As Wang et al. (2009) note, although families and members of the local Chinese community can provide psychological support to the person living with the mental illness, they can also be bearers of stigma associated with mental illness in the community.

For five of the Chinese participants in this study, it was noted that family members provided ‘support’ related to their mental illness prior to the individual seeking formal mental health services e.g., hospital or a psychiatrist. However, this support often led to delayed treatment. In this vein, Participant J, a health care provider, discusses her clinical experience working with Chinese women in the following interview excerpt,

well my experience...particularly with umm Chinese women what I’ve noticed is they often have had a very severe mental illness for many years and have been quietly looked after by the family in the home with the result that they haven’t had any treatment which would have made a huge difference and umm usually...you don’t get the call until the family absolutely can’t cope anymore which it’s much better if it’s treated early. Participant J

This finding is congruent with Lin’s findings (1983) that families would cope with a family member affected with a mental health issue in the home for a long time before allowing trusted outsiders such as friends or elders to assist.

According to other authors writing on this topic, informal networks of people such as family and friends first observe behavioural or emotional problems (Spencer et al., 2010; Wong, 2007) and try to cope before using formal mental health services. It is

the role of family to act as an intermediary between the affected individual and mental health services (Ran et al., 2005; Wong, 2007). For some of the participants in this study, it was family members who noticed symptoms and assisted the individuals to get help for their mental health. As one Chinese participant describes,

I got sick and I took stress leave off work and I went... well my ex-husband, well my ex-husband now but... he took me to my family doctor and then he suggested I go to psychiatry, so I ended up getting admitted at St. Vincent's. Participant G,

Participant G's ex-husband was the first to notice she was not well and assisted her to seek help from her family doctor. This is congruent with the findings of Spencer et al. (2010) and Wong (2007). The family who could not manage, required the assistance of the family doctor as additional support. This subsequently led to a hospitalization when the participant was diagnosed with Schizoaffective disorder.

In this study, participants noted that families not only helped Chinese women to access services but also provided support in this way. In the following interview excerpt a Chinese woman describes the importance of this connection,

support from all directions I have to say and family support is number one, which unfortunately of you know a few people that I've come across that have the same condition as me, that they don't even have family support ... [they are]abandoned. Participant A

Participant A expressed the importance and appreciation of having family support. This was particular to having a mental illness and the concern about not being abandoned as a result. Participant I, a non Chinese participant felt that although she had the support of her father when accessing mental health services, the same was not true about her siblings. She explains,

My family never talked about it, my father came with me to visit the doctors all the time, he was the only one. I have 10 brothers and 3 sisters and half have mental illness. No one has ever come to see a physician with me. Participant I

Most of the participants had families who were aware that they have a mental illness. Some families and family members were more supportive than others. A contributing factor was the ability of families to accept and understand the woman's mental health condition.

Friends were another important form of informal network that assisted Chinese women with accessing mental health services. As one Chinese participant explains in the following,

my friend just take me to the emergency and explain my situation and then so they just ask me to stay in the hospital and then finally they can like diagnose what's the problem and also could prescribe me medication. Participant F

The importance of having friends who are supportive was particularly helpful in Participant F's case in accessing mental health services. Participant F's family was not supportive. Her friend had noticed she displayed symptoms of depression and encouraged her to seek help. Participant F would not have received help with her mental illness without her friend's assistance as her friend had experienced similar symptoms in the past and recognized a need for Participant F to seek help. This for many is an important component of the recovery process. The concept of recovery in mental health is a personal subjective experience of optimism, empowerment, interpersonal support, peer support and stigma reduction (Chiu et al., 2010) and adequate social supports through interaction with others in a supportive trust based relationship has been found to be associated with better outcomes of recovery (Chiu et al.)

Family and friends emerged as a significantly important facilitator of access to mental health services for all of the Chinese women interviewed in this study. It was helpful for Chinese women to have social support as a means to navigate access to mental

health services. This was facilitated by encouragement from others to seek help and by knowing a family member or friend who was non-judgmental and was there for them. In particular, the women found this kind of support assisted them to get help with their mental illness and to work towards the path of recovery. As one Chinese participant said, “There needs to be a lot of back up from different types of direction, different type of feel to support someone with a condition to be able to function in their daily lives” (Participant A). This participant was illustrating the importance of feeling emotionally supported by friends by being there for the person living with mental illness as they undergo treatment and enter the recovery process.

The experiences of social support that were commonly found by participants in this study was from family and friends. All participants felt that social support was important in not only being able access mental health services but to be able to function despite having a mental illness. However, Chinese women also acknowledged their families could be the biggest source of stigma that affected their access to mental health services.

Language and Access

Language⁶ came up in all interviews with Chinese women and health care providers as a constraining factor to accessing mental health services. This is consistent with the findings of Mok (2006) and Simich et al. (2009). Language barriers have adverse effects on access to health care, quality of care, rights of patients, patient and provider satisfaction and patient health outcomes (Bowen, 2001). Language barriers affect client initial access to services as well as treatment (Bowen, 2001). In Health Canada’s report

⁶ Here I am referring to the ability to understand spoken language, and read information.

(Bowen, 2001), it is noted that the effective use of language helps to build health care the provider-patient relationship.

Although language did not prevent the Chinese women in this study from receiving mental health services, most of the women felt that having mental health services available in Chinese (Cantonese or Mandarin) would be helpful. However, although Chinese women preferred to have a health care provider who could speak Chinese they still felt it was more important for health care providers to have an understanding of their culture than to necessarily speak their language, i.e., that the health care provider might have some understanding of those factors that were important to their health and well-being.

From my experience as a clinician I have noted there are few mental health services available in Chinese, often due to the fact that are few providers who actually speak Mandarin and/or Cantonese. In the following interview example, a Chinese participant describes how language can be a constraining factor,

if there are more different language like speakers helping in the mental health team, I guess that will be quite helpful, especially for Chinese women because like Chinese women I guess for most of them like their English like might not be able to get to the level... like they won't be able to understand especially when they need to share what happens to them in the mental issue... in the mental health issue, so it will be much better if there are some more Chinese working volunteers or Mental Health Team staff. Participant F

In a similar vein, a health care provider also discusses this issue in the following,

lack of variety of services that are offered in terms of ..for age group, for different cultures not being language specific, not responding to the demographics of the community. Participant K

According to the Health Canada report (Bowen, 2001) problems associated with language barriers include: the adverse effects on the initial access to health services and

health promotion/prevention programs; an increased risk of hospital admission; decreased quality of care associated with the problematic interactions with health care providers; and, difficulties in the ability to gain informed consent and satisfaction of care.

Lack of Coordinated Seamless Care and the Intersection with Mental Health Literacy

During the participant interviews, all participants had experienced a disconnect from and lack of coordination of mental health services; a disconnect that seemed to differ somewhat between Chinese and non-Chinese women.

Participant I, a non Chinese woman did not have psychiatric follow up for 16 years and was in and out of hospital during this time period. When asked about how she became aware of mental health services in her community, she noted that when she was 30 years old, she was given the name of a mental health team access. She was not offered psychiatric follow-up until she had accessed the system through multiple hospitalizations. In addition, Participant I did not have positive experiences with general practitioners, who also can be providers of care for mental health issues. As explained by Participant I, “I find that GP’s aren’t willing to talk about mental health or they treat you different once they find out that you have a mental illness.” In this case, the experience of stigma (perceived) within the mental health system, i.e., her experiences with general practitioners, intersected with the way in which services were offered. There was a general lack of coordination in services and a sense of alienation experienced by the participant fueled by being treated ‘differently.’ Whether perceived or intended stigma⁷, this participant experienced a disconnect from the system of care.

⁷ Perceived stigma is a type of stigma individuals anticipate to experience. Intended stigma is a type of stigma deliberately projected to individuals.

Similarly another non Chinese woman experienced a barrier when she couldn't access counseling through a mental health team. Access was not possible until she ended up ill enough to warrant treatment, i.e., a hospitalization. She discusses this in the following interview excerpt, "I could not access counseling with the mental health team where I lived because I was considered to be not a suicide risk and not serious enough to warrant mental health intervention" (Participant H). Participant H expressed frustration with the way in which she finally was able to access services. A mental health crisis was her entry point to the system. Here a structural issue within the system created a barrier to access. She could not access help until it was deemed her mental condition was serious enough to meet the mandate for services. The perceived mandate of mental health services, in keeping with an interpretation of the 1998 Mental Health Plan (Ministry of Health), to treat people with 'serious and persistent mental illness,' resulted in this participant's inability to access the mental health system; hence she experienced feeling unsafe. At the time of interview, this participant was receiving psychiatric follow up from her family physician, who she found very supporting – a different experience than that of Participant I.

For the Chinese women in the study, a lack of coordination from the system of care manifested somewhat differently for each of them. This was described by both the health care providers and Chinese women interviewed. As one health care provider notes in the following,

lack of knowledge on how to access it, there can be there language barriers, there can be cultural barriers, there can be family barriers and misunderstanding when they do access it, can turn the experience...turn the person away from accessing it.
Participant K

This excerpt illustrates the complexity of being a Chinese woman living with a mental illness and trying to navigate the mental health care system. Lack of knowledge about where and how to access services emerged as a common theme in the interviews. The inability to know where to go for assistance was perceived by health care providers as a significant barrier for Chinese women who were needing to access the mental health system; an experience that also was acknowledged by the Chinese women. This ‘lack of knowledge’ related to the ‘system’ was similarly found by Mok (2006) and Simich et al. (2009) and the Mental Health Commission of Canada (MHCC) (2009). For example, according to the report by the MHCC (2009), some immigrant (including Asian Canadians), refugee, ethno-cultural groups and racialized groups are not aware of mental health services available or understand how the health care system works. If people do not know where to get help, they may wait until their symptoms are more severe before they receive care (MHCC, 2009).

Wait times affected access for both Chinese women and non Chinese women.

This was noted in the following excerpt from an interview with a health care provider,

how easy it is to access, like if you have a long wait time, if you go to your family doctor and you have to wait to wait two years to see a psychiatrist or if there is a prolonged wait, I think influences a lot. Participant K

The literature confirms there are administrative challenges in service delivery, including long wait lists (Mok, 2006; Lai & Chau, 2007), which affects coordination of care for individuals in need of help. When being referred to a mental health service, such as a mental health team or a psychiatrist, Chinese women in this study encountered long wait times. A Chinese participant describes her experience when being referred to a mental health team for additional support by her family physician in the following: “during the

time that I really needed help it took like three months before I could really get in” (Participant E). This participant struggled with her mental health issues while waiting to be followed by the mental health team. During the waiting period, her family physician would ask if she was suicidal, a factor, which would have warranted immediate access to care and a possible admission to the hospital. The participant expressed frustration with the lack of support she received during this time because she felt that she needed more support than what her family physician could provide.

Health care providers interviewed felt that the health care system can be overloaded, which can explain long wait times for services. Canadians wait an average of 18.6 weeks for psychiatric treatment (Huras, 2008). This figure illustrates the difficulty for individuals with urgent needs. As is well documented in the literature, when people have to wait a long time for specialized services as such mental health, it can lead to a relapse of symptoms or hospitalization (BC Ministry of Health, 1998).

Women’s experiences of mental health services were influenced by a number of factors. For the non Chinese women access to services was primarily shaped by structural barriers related to an interpretation of the mandate of mainstream mental health services within the mental health teams and a general lack of continuity in service delivery. For the Chinese women obstacles to access were also related to other issues, e.g., a lack of attention within the mainstream system to mental health literacy and long wait times, even for those issues deemed urgent. However, for the Chinese women these challenges intersected with a lack of attention in the system to ‘difference,’ e.g., language and cultural norms.

Health Care Providers and Peer Support Workers: Navigating Mental Health Services

All participants (Chinese and non Chinese women) accessing mental health services found the relationships with health care providers were important to them and to their health and well-being. Participants saw a variety of providers, e.g., family physicians, psychiatrists and/or mental health clinicians. As one Chinese woman described, “To see [the] doctor and the worker ... mostly the doctor give me pills and check my blood work and to see my health and the worker here is so helpful” (Participant B). All participants felt it was important to receive regular follow up for their mental health. In addition, when reflecting upon past experiences, particularly incidents that led to their first hospitalization, all participants noted that the medication they were being prescribed by their doctor was helpful with symptom management. As one participant notes in the following,

Well the helpful part is that they, aside from the psychiatrist that is in charge of really prescribing the medication, depending on you know the feedback that you give him or her, his or her assistant, which is a case manager, is there to help you one-on-one to understand all your hardship and your needs and kind of be there to help you get back on your feet. Participant A

and another participant,

like the first thing is you feel that there is someone like always there to listen and to help, especially when... like when your situation is really bad and sometimes like you don't want to upset your family members or you feel that like other people may not like really understand what's happening. Participant F

A non Chinese woman shares a similar positive experience with health care providers in the following, “the doctor and therapist that I have now at the mental health team they talk to you like a real person, they don't treat you like you have a mental illness” (Participant I).

Generally, participants felt comfortable with their health care providers. They felt they were listened to with an empathetic ear, supported and provided assistance with their needs e.g., financial support and advocacy. They also felt that at times, family or friends would not be able to understand things of concern without thinking immediately that the participant was becoming unwell and arousing worry. For participants whose symptoms were well managed, working with a health care provider to initiate and continue with treatment resulted in improved health. In this regard, the participants expressed the view that having dialogue with their health care providers and receiving feedback was helpful to assisting them to meet their goals and to overall an overall improvement in health and well-being.

Although the inability of health care providers to speak Chinese can be perceived by some to be a deterrent to receiving care (Chen et al., 2009; Chen et al., 2010; Lai & Chau, 2007) and understanding the culture (Lai & Chau), in this study there was a variability of experience – some had health care providers who were Chinese and some did not. Even though for some participants there was a preference for a health care provider who could speak the language, it did not prevent them from being able to work with health care providers who could not speak their preferred language, i.e., Cantonese or Mandarin. Since the women in this study were able to speak English, they received care in English.

Peer support workers as facilitators of access to mental health services came up in several interviews. Peer support models are underpinned by the belief that significant interpersonal relationships and a shared sense of community lay the foundation for the process of healing (Adame & Leitner, 2008). In the settings in which I conducted this

research, peer support workers are individuals who have a mental illness and have an interest in helping others with similar difficulties. Mental health consumers give and receive peer support despite having a mental illness (Bourchard, Montreuil, & Gros, 2010). They provide help by listening empathetically, provide emotional support, advocacy, role modeling, interpersonal skill and other skills training. The role of peer support workers is to help address individual issues or shared concerns (Bourchard et al.) related to mental health. One Chinese participant in the study shares her belief about peer support in the following interview excerpt,

because I feel the people, because of peer... they have some problem before and right now is recovered a lot, so and if illness people, they feel if a same peer they wait, they don't feel stressful, they feel peace, don't feel like other people have to socialize and that feeling is a total different. Participant C

Interestingly, Participant C is a peer support worker and decided to become one in order to help others. Participant C found that peer support workers were helpful as they have experience living with a mental illness and have been engaged in the journey of recovery. Peer support workers encourage people to be active participants in their recovery (Adame & Leitner, 2008). Peer support workers share experiences and providing support.

Participant I, a non Chinese participant, also a peer support worker, shares her perspective in this excerpt,

because of all the ups and downs I'd been through myself that were so severe and I have learned from it and then now that my life is good, I can help other people. I want to go back and help others. Participant I

Sometimes when individuals are diagnosed with a mental illness, they feel they are not able to move forward with their lives. This could be attributed to feeling socially isolated. People with mental illness tend to have small social networks, which often lead to feeling stigmatized and lonely (Bourchard et al., 2010). Within peer support settings,

there is an opportunity to share similar life experiences and feelings of social isolation related to stigma, which helps to increase social networks and foster a sense of community (Adame & Leitner, 2008).

Within mainstream mental health services in the lower mainland in British Columbia, individuals with a mental illness can be referred to the peer support program where they can work 1:1 with this individual. Individuals with a mental illness also can self refer. Generally referrals are made by health care providers working in hospital and clinical settings who have prior knowledge about peer support workers and the way in which they may be able to assist the client/patient. In this study, health care providers were the source of referral for the participants who were recipients of peer support.

Through engagement with individuals living with a mental illness, peer support workers help to inspire hope and support recovery. This requires an opportunity for peer support workers to recognize and nurture potential (Moll, Holmes, Geronimo, & Sherman, 2009) with individuals who have a mental illness. Bourchard et al. (2010) found peer support helped to decrease people's anxiety, isolation, stress levels and helped individuals to feel hopeful and supported. Peer support workers help consumers to increase their independence and participate in activities and assist in creating social contracts where individuals are supported to develop feelings of being supported despite having a mental illness (Bourchard et al.). Adame & Leitner (2008) found when individuals receive peer support they develop a new sense of self-worth.

Participant B also is a Chinese peer support worker who converses in Cantonese and Mandarin. This individual believes that peer support workers could help individuals become familiar with new surroundings such as helping people to be comfortable to take

public transit to go places. As she notes in the following, “Maybe they are not familiar with the new place, so they need to like having PSW, peer support to guide them to take the bus sometimes right” (Participant B). In the following another participant is talking about the merit of having peer support workers in multiple settings, including in the psychiatry ward at the local hospital, which is one access point of mental health care,

because we have the Chinese Peer Support, yeah, there’s definitely you know if someone speaks Chinese umm, and being in the hospital as well as in the community Jane Doe (co-ordinator of Chinese Peer Support program) also has peer support workers in the hospital. Participant E

Informed by their past experiences, peer support workers can help individuals who are newly diagnosed with a mental illness or having a relapse of symptoms by being empathetic. This kind of support can be achieved through the sharing of knowledge related to mental health, general conversation and activities (Coatsworth-Puspoky et al., 2006). Therefore, it is not surprising that Moll et al. (2009) found peer support workers improved consumers’ quality of life and social functioning. Peer support workers who are of Chinese descent and able to speak the language (e.g., Cantonese or Mandarin) can reach out to Chinese women in the hospital setting. One Chinese participant in this study speaks about peer support in the following, “Umm maybe... I was thinking [I could] be a peer support [worker] one day to support the Chinese mental health... support Chinese consumers, yeah, to be... speak Chinese to them, have the same empathy, sympathy for them” (Participant D). This type of support could be especially important to Chinese women with a mental illness given the language issues and stigma associated with mental illness.

Interestingly in the review of literature, peer support did not emerge as an a valuable resource in relation to Chinese women accessing mental health services in

Canada. In this study, relationships with peer support workers were important to Chinese women as they were helpful in navigating mental health services and associated supportive resources.

For several of the participants in the study, peer support was perceived as helpful. A couple of the participants (B&C) went on to use their experiences of recovery with their mental health to assist others in the form of peer support. Some of the participants thought that being of the same ethnocultural background and speaking the same dialect e.g., Cantonese or Mandarin were important factors. However, although language and Chinese ancestry were thought to be positive, they were not thought to be essential requirements, for example, Participant D had a very positive experience with an English speaking non-Chinese peer support worker. This experience had motivated her to want to be a peer support worker. She wanted to help others through the use of empathy, which she found to be helpful from her own experience. Although a shared ethnocultural background and language were perceived as helpful components of peer support and support towards recovery of mental health, processes that included empathy and a sharing of the peer worker's recovery processes and experiences were thought to be equally important elements of peer support.

Advocacy provided by health care providers and peer support workers was thought to be pivotal to moving forward once the Chinese women accessed mental health services. According to the World Health Organization (2003), mental health advocacy is defined as the promotion of the human rights of persons with mental disorders, which include the reduction of stigma and discrimination.

Through the advocacy of health care providers and peer support workers, some participants were able to benefit from their assistance, for example, economically as described by one participant in the following,

I don't think I would have been able to get that CPP for my income now, umm but I think there was a lot of... like there was advocates that I dealt with, umm the team which the Richmond. Participant G

and another participant,

Of course, because you have that advocacy, you have that extra person there who's saying if you need that help, you know what let's do this together, let's keep trying, if not let's try a different avenue. Participant E

Participants E and G found that through accessing mental health services, they were able to get assistance with everyday living, which helped to increase their economic security and independence. For example, most of the participants found that their health care provider such as their doctor and mental health clinician assisted them to get financial assistance whether it was CPP (Canadian Pension Plan), disability benefits or provincial disability benefits. In particular, the women noted that they got assistance with navigating the process of getting financial assistance in a number of ways, including assistance with documentation processes. Financial assistance was an important aspect of support for the participants in this study. It enabled some participants to be able to live with family members or independently without being a financial burden to family. This does not necessarily mean the women were happy being on financial assistance as they were unable to work in order to provide for themselves and had to rely on government agencies in order to be sustained financially with daily living. Even though families can be a great source of financial and other support, as noted earlier in this chapter, they can create stress for individuals.

Prior to being able to access the support of health care providers the participants spoke about the need for them to be able to acknowledge that they had a mental illness, which impaired their ability to work full time or to be self sufficient. Receiving financial assistance enabled women to be more independent by being able, for example, to access an affordable bus pass and/or vocational services for individuals with disabilities and/or educational grants etc. It is not unusual for health care providers to become advocates (World Health Organization, 2003) for consumers such as advocating for financial assistance and other consumer rights.

The use of peer support workers was found to be helpful. They are able to help clients with accessing resources or encouraging individuals to fight for their rights. As Participant I describes in this excerpt:

You have to fight for a lot of things you want and a lot of people aren't willing to fight. They're tired, they're worn out because of their illness. They don't have any fight left in them, so one of the things you can do is go upstairs here. There is the Motivation, Power and Achievement Society (location of choice for interview for Participant I) for people with mental illness and they have advocates and they'll put you on the right track for anything. Participant I

Advocacy was an important component of care for the women in this study. The women received support from health care providers and peer support workers to access mental health services and associated resources, including things like financial assistance, which in turn enabled them to live independently and supported the recovery process.

Summary

This chapter focused on five themes that emerged through Chinese women's experiences of accessing mental health services. Before accessing mental health services several participants found that they needed to grapple with the stigma associated with mental illness in their ethnocultural community. Chinese women received support from

family and friends as important sources of support, however, families were also perceived as a source of stigma. Language was perceived as an important component of positive access experiences. In addition, Chinese women experienced a lack of coordination of mental health services when accessed. Lastly, while navigating the health care system, Chinese women found health care providers and peer support workers helpful by providing support through advocacy e.g., supporting access to financial assistance. Chinese women's experiences of mental health services intersected with structural issues of the health care system such as an absence of Mandarin and/or Cantonese speaking providers and information in those languages to shape/influence their experience and access.

In the next chapter, implications and recommendations in relation to nursing practice, education, research and policy will be discussed. In addition, a conclusion of the study will be presented.

CHAPTER FIVE: RECOMMENDATIONS

Introduction

Through analysis of the participant interviews, five main themes were identified: 1) Stigma and Mental Illness; 2) Social Supports: Connections with Families and Friends and the Double Edged Sword; 3) Language and Access; 4) Lack of Coordinated, Seamless Care and the Intersection with Mental Health Literacy; and, 5) Health Care Providers and Peer Support: Navigating Mental Health Services. Women's experiences of access to mental health services intersected with the structure of the health care system to shape/influence access and their experience of health and well-being. In this Chapter I will discuss recommendations based on these themes that could be applied to the field of nursing in clinical practice, education, policy and research. A conclusion will then be presented.

Recommendations

Clinical Practice

Nurses as health care providers, working in all clinical areas could do several things to assist in enhancing access to mental health services for Chinese women. There are several recommendations for nurses in relation to nursing practice based on the findings of this study and what we already know from the literature.

1) Establishment of the Therapeutic Relationship and Relationship Building

To begin, when nurses work with all clients/patients in the community or within hospital settings they should strive to establish rapport, which is fundamental to any therapeutic working relationship. Respect, honesty, trust and effective communication are key principles to establishing rapport (Registered Nurses Association of Ontario

[RNAO], 2002). This assists nurses to help build trust, which is fundamental to the provision of safe and effective care. Trust, respect, professional intimacy, empathy and power are components in a nurse-client relationship (College of Registered Nurses of British Columbia [CRNBC], 2006). Establishment of rapport could enable Chinese women to trust nurses and to have a good experience when receiving care. These experiences could be shared with their family or friends. In this study, Chinese women found that health care providers such as nurses were helpful in assisting with regaining their health and independence.

As with any population, nurses need to involve families in treatment planning as appropriate. Family is an important support for many Chinese people living with a mental illness (or any other type of illness) (Lam et al., 2010; Wang et al., 2009; Wong, 2007) – a finding that has been supported in this research. Family focused services with resources to provide, for example, health education related to mental health and illness, would assist in providing support for the family and affected individuals.

Mental health literacy has positive effects for establishment of therapeutic rapport and relationship building. Mental health literacy assists in building knowledge, understanding and acceptance of mental disorders so they can recognize and ask for treatment as soon as possible. This assists individuals to know health care providers are there to help improve their mental health through a therapeutic relationship. Another effect of mental health literacy is that it helps people to know they can receive care from health care providers to create great acceptance for conditions and their treatments (Scheffer, 2003).

2) Language

In mental health care settings, hiring qualified nurses who speak Chinese (Cantonese/Mandarin) would be an asset. It would be helpful for Chinese women accessing mental health services to work with a health care provider who not only seeks to understand the culture and other factors that are important to the health and well-being of the client but is also able to express themselves in the preferred language of the client. Language is an important component in building rapport. Although I understand that being Chinese does not guarantee that the nurse (or other health care provider) would necessarily understand Chinese women's experiences (and/or culture) or speak the language, the Chinese women in this study identified this as something, which might assist with rapport building.

The use of professionally trained interpreters through the provincial language service (Provincial Health Service Authority), which uses qualified professional interpreters are essential to providing equitable access of care (Bowen, 2001). This could be used to support the provision of safe and effective care. The use of hospital/clinic-based interpreters assists in meeting the immediate needs of the health care setting and the needs of the individual who is need of care (Bowen, 2001). This is important for people with mental health issues to be able to use the language in which they can communicate to best explain what they are experiencing which may lead to better outcomes (Mental Health Commission, 2009). The individual who is to receive care could make this request by being informed such an option is available. It also would be helpful to have resources in different languages e.g., written materials or videos

providing education on mental health or talks in the community illustrating how the health care system can help people with mental health.

3) Advocacy

In this study, it was found that advocacy was an important aspect of practice associated with good outcome. For example, study participants noted that assistance with disability claims assisted them in the recovery process, particularly through their ability to become more independent. This was through the assistance of health care providers such as nurses and peer support workers. Nurses can also be involved in action that pushes for legislative change, for example, to decrease wait times for individuals to receive psychiatric care in the community in order to improve access; this through organizations such as the Association of Registered Nurses of British Columbia (ARNBC) whose mandate it is to address social issues that impact health and well-being (Association of Registered Nurses of BC).

The Mental Health Commission of Canada (2009) supports people having equitable and timely access to appropriate programs, services and treatments integrated to their needs. Nurses could advocate for more qualified health care providers who speak a second language to be hired. BC Nurses' Union could be used to press for improvements in the work environment (BC Nurses' Union). This kind of advocacy could assist in offering services in different languages and increase the ability of the system to reach more diverse populations. Advocacy activities come in many forms including raising awareness, dissemination of information, education, training, mutual help and counseling (World Health Organization, 2003) – activities that can be provided by health care providers, peer support workers and mental health consumer groups.

Nurses could also promote the role of peer support workers. Findings of this study would support this role in mental health inpatient and community settings. Peer support workers were good advocates for resources to address the needs of mental health consumers both in the hospital and in the community – often addressing issues they also had experienced as important. Because individuals can self refer, it would be important that this resource be made apparent to consumers in a number of different ways, through mental health settings and community agencies (Chinese and non-Chinese), to name a couple.

4) Collaboration

Nurses could promote interaction for Chinese women with peers who have mental illness. This would be through collaboration with peer support programs where a referral for a peer support worker could be made. This would be an example of how accessing personal supports is a means of providing consumer centred care; this to assist the client to engage in the process of recovery (Ministry of Health, 1998).

The World Health Organization and World Organization of Family Doctors (2008) supports the integration of mental health services into primary care as the most viable way of closing treatment gaps and ensure people get the mental health treatment and support they require. The provision of mental health services within primary care has been demonstrated to be an effective and efficient way to assist in health promotion, early identification, treatment, management of mental illness and referral to specialty care if required (Health Canada, 2006). In addition, using this model, mental and physical health are seen to be more interwoven and integrated (World Health Organization and World Organization of Family Doctors, 2008).

Nurses also could collaborate with primary care providers to break the resistance of individuals seeking specialty care such as psychiatry. This could also assist in decreasing stigma and increasing awareness of mental health services. Through collaboration with other health care providers in different clinical settings, nurses can be informed about how people can access mental health services e.g., through primary care, particularly those who don't work in mental health care settings.

Collaboration with community agencies that service the Chinese population would be helpful in order for mental health promotion and education. This would help raise awareness of mental health illness and the possibilities for engagement with the process of recovery, i.e., mental health literacy would be supported.

Education

There are several recommendations in the form of education, suggested for nurses that are informed by the findings of this study.

1) Undergraduate Nursing Programs

Most nursing students in a baccalaureate programs are provided with some mental health education, whether theoretical and/or clinical practice. It is fundamentally important that nurses have foundational knowledge in mental health such as assessment, treatment of mental illness, prevention, and promotion of mental health and well-being regardless of where they will be working. As future nurses, they would be able to help [Chinese] women who may be having issues with their mental health by being able to recognize their need for help and to assist them with access to appropriate resources. In addition, nursing students need to learn appropriate communication skills to build rapport, which is integral in a therapeutic working relationship.

2) Culture

Nurses can be trained to provide culturally safe/competent care by beginning all of their relationships with a curiosity for understanding the key personal and other factors that shape/influence the health of their clients. For example in this study, key for many of the Chinese women were the beliefs regarding mental illness/health and the associated beliefs regarding 'loss of face,' filial piety and shame, all of which played a pivotal role in access to services for these women. Therefore, stigma associated with mental illness was found to be highly influential regarding when and how women accessed services. Nurses need to be aware that the mind and body are not separate for many Chinese. In addition, although somatization was not brought up in the participant interviews in this study, nurses need to know that somatization is often a symptom of mental health concerns/mental illness for many people (Lam, 1995; Wong & Tsang, 2004; Ran et al., 2005), including Chinese clients/patients. As a cautionary note, it is important that nurses not generalize particular characteristics to a group of people such as Chinese patients, however, it is helpful to know that there may be 'differences' associated with particular groups of people that influence health and well-being (Smye, 2011). Nurses need to engage with clients/patients in ways that invite a sharing of information crucial to the provision of safe and effective care.

Nurses need to be educated on stigma and its many layers e.g., institutional, public and self/individual. It was a powerful oppressive force for all of the women in this study, with unique features for Chinese women. Nurses need to be allies in the anti-stigma campaign currently underway in Canada. For example with the anti-stigma and anti-discrimination initiative through the Mental Health Commission of Canada (2008),

there are partnerships with communities in program delivery that includes the involvement of mental health consumers. ‘The Opening Minds’ program is a Mental Health Commission of Canada (2011) initiative to change attitudes and behaviours of Canadians towards people living with mental health issues through contact-based education using mental health consumers to share their experiences. Their target audience are health care providers, youth, workplaces and the media (Mental Health Commission of Canada, 2011). Nurses can use their leadership skills and expertise (Mental Health Commission of Canada, 2008) in helping with such initiatives.

3) Awareness of Mental Health Services

It is important that all nurses be aware of mental health resources that exist within and outside the health care system e.g., general practitioners (GPs), psychiatrist and other mental health specialists such as psychologist and counselors, how to navigate into mental health programs, consultation and community resources. In relation to Chinese clients, nurses should know where to find information regarding special resources such as interpreter services and mental health services that are offered in Cantonese and/or Mandarin. This would enable Chinese women to be aware of services that they could utilize and help increase mental health literacy. For example, as noted above, nurses can assist in increasing awareness of and referral to peer support workers through their collaborations with other health care providers.

4) Education Role

One of the important roles nurses play is the role of educator. Nurses are in a pivotal position to increase people’s knowledge about mental health through mental health promotion and by increasing mental health literacy; this to assist to reduce stigma

associated with mental illness. Mental health promotion can improve pathways to care (Mental Health Commission of Canada, 2009). This could be through engagement of mental health consumers and supportive networks in an anti-stigma campaign. For example, educating the public could include providing information regarding what constitutes mental health/illness, the myths of mental illness, forms of treatment and how having social support can be helpful to for recovery. Nurses could provide education to the Chinese community and associated services and agencies regarding existing mental health services, access to those services and the merits of mental health care. Providing education to the community creates better awareness, response and knowledge of treatment and services (Ministry of Health, 1998).

Policy

The findings of this study support the need for policy decision-makers to consider ways of addressing long wait lists. It precluded timely access to mental health care and for services to be in place that provide essential information in the preferred language of clients/patients, including for example, professional interpreters. Nurses as important providers of care can use their expertise to influence policy. As a stakeholders in health care and important advocates for clients/patients, nurses are in a good position to engage with policy decision-makers and other health care professionals with the development of strategies to improve access to mental health services. In addition, nurses can use their voice to help change mental health standards, protocols and policies to the betterment of mental health care/services and supports for clients/patients. Nurses can engage with decision making processes, for example, by sitting on community and workplace

committees and boards such as the Canadian Mental Health Association and the Mood Disorders Society and others, local, provincial and national.

Need for Further Research

At present there is not much research in Canada on Chinese women who are not recent immigrants or older adults and their access mental health services. It would be interesting to engage with research focused on Chinese women and their access to mental health services with a slightly different group of Chinese women. For example, the participants in this study mostly had a diagnosis of Bipolar disorder, Depression and Schizophrenia/Schizoaffective disorder. In my view, it would be helpful to learn from the experiences of Chinese women accessing mental health services with a different diagnosis e.g., substance use, anxiety, eating disorders just to name a few. As well, research conducted with participants in Chinese (Mandarin or Cantonese) would provide an insight into this topic from a different perspective. This could be facilitated through the use of a professionally trained interpreters. There needs to be more research on the disconnection of accessing mental health services due to stigma for Chinese women.

As peer support was an important point of connection for the Chinese women in this study, it would be useful to examine the efficacy of this approach more closely to see, for example, how this role influences/shapes access to mental health services. In addition, there is a gap in the literature regarding the perspectives of the families of Chinese women who live with someone with a mental illness to examine their perspectives on access to mental health services. This was a limitation of this study and would provide another perspective– one that might provide further insights on this topic. For example, this could assist in exploring further the notion of stigma associated with

mental illness as it exists within some Chinese families and communities and its influence on access and health. This could provide important insights that would influence strategies for working with Chinese women who live with a mental illness and to working with families who share this perspective to effectively address this unique form of stigma.

Conclusions

This research study focused on Chinese women's experiences of accessing mental health services. The review of literature demonstrated a lack of research focusing on Chinese women's experience of access to mental health services in Canada.

Interpretive description was the research method used for this study. Participant interviews with Chinese women, non Chinese women and health providers were completed. Through data analysis, several themes emerged. Chinese women experienced stigma in relation to mental illness within themselves and their ethno-cultural community, which was a constraining factor to accessing mental health services. Interestingly, it was the support of family and friends who helped some of the Chinese women to seek help for their mental health. However, family was also a source of stigma for Chinese women. Challenges with language abilities emerged as a theme. Chinese women experienced a lack of coordination with the health care system when accessing mental health services. Health care providers, peer support workers and health care providers were found to be helpful to the participants as they navigated through mental health services. They were a source of support to improving the health of the participants, for example, by facilitating access to disability benefits and supporting client independence.

Several recommendations have been made that could apply to clinical practice, education, research and policy. With regards to clinical practice, nurses need to be culturally competent when working with patients in mental health care settings. The Canadian Nurses Association (2010) defines cultural competence as the application of knowledge, skills, attitudes or personal attributes required by nurses to maximize respectful relationships with diverse populations of clients. There were recommendations on providing care with regards to language. Nurses can advocate and collaborate with community agencies to enhance access to services.

Nurses can be educated on mental health in undergraduate nursing programs, to have increased knowledge about culture and awareness of mental health services. The role of education by nurses is important in order to increase mental health literacy in hopes of decreasing stigma and discrimination. This chapter also discussed the need for further research with regards to Chinese women and access to mental health services.

This study demonstrated a gap to the existing literature. It is hoped that the findings of this research will contribute to the science of nursing. Hopefully practice changes through education and further research will assist in improving access to mental health services for Chinese women where they will be supported in getting help without feeling ashamed.

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Appendix A: Consent Forms
THE UNIVERSITY OF BRITISH COLUMBIA



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For the Research Project
“Chinese Women’s Experiences of Accessing Mental Health Services”

**Consent Form for Participants-Version 2011
(Individual Interviews)**

Research Team:

Masters of Science in Nursing Student: Susan Chong, RN, BNSc, BA

Supervisor: Victoria Smye, RN, PhD., Assistant Professor

Background: Research done with Chinese populations in Canada has focused on the elderly and immigrants accessing mental health services. Very little research exists about adult Chinese women and their experiences of accessing mental health services. Your participation in this study will help with this knowledge gap and could potentially influence accessibility of mental health services for Chinese women in a positive light.

Purpose: The purpose of this study to explore Chinese women’s experiences of accessing mental health services. The intent of this study to explore what facilitates or is problematic of access to mental health services.

Study Procedures: If you choose to participate in this study, the researcher (Chong) will interview you once or twice for up to 45 minutes at a time. These interviews will take place in location of your choice or at a mental health site and scheduled at a convenient time for you.

The interview will be digitally recorded. The focus of the interviews will be on Chinese women’s’ experiences of accessing mental health services, more specifically what are barriers and what facilitates access.

Risks: You may feel tired thinking or talking about your experiences. If you do become tired, you may choose to stop the interview at anytime or may withdraw from the study completely.

If you are not comfortable with continuing the interview, you may choose to stop the interview at anytime or may withdraw from the study completely.

Privacy and Confidentiality

By participating in the study, all information obtained from you will remain anonymous, where no identifying information will appear in any document about this research. All documents and interview recordings will be identified by a code number and kept in a locked filing cabinet in a locked office. The recordings from the interviews will be stored in a computer that is password protected. These recordings will only be accessible to the researchers.

Contact: If you have any questions or want further information about this study, you may contact Susan Chong at (xxx) xxx-xxxx or her supervisor Victoria Smye at (xxx) xxx-xxxx.

If you have any concern about your participation as a research subject, you may contact the Director of Research Services at the University of British Columbia at (604) 822-8598.

Consent: I understand my consent to participate in this study is entirely voluntary. I may refuse to participate or withdraw from the study at any time. This does not jeopardize any access to mental health services presently or in the future.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

Printed Name

Participant Signature

Date



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Background: Research done with Chinese populations in Canada has focused on the elderly and immigrants accessing mental health services. Very little research exists about adult Chinese women and their experiences of accessing mental health services. Your participation in this study will help with this knowledge gap and could potentially influence accessibility of mental health services for Chinese women in a positive light.

Purpose: The purpose of this study to explore Chinese experiences of accessing mental health services. The intent of this study is to explore what facilitates or is problematic regarding access to mental health services. A small subsample of non-Chinese women will also be interviewed to examine the similarities and differences across women’s experiences.

Study Procedures: If you choose to participate in this study, the researcher (Chong) will interview you once or twice for up to 45 minutes at a time. These interviews will take place in location of your choice or at a mental health site and scheduled at a convenient time for you.

The interview will be digitally recorded. The focus of the interviews will be on women’s experiences of accessing mental health services, more specifically what are barriers and what facilitates access.

Risks: You may feel tired thinking or talking about your experiences. If you do become tired, you may choose to stop the interview at anytime or may withdraw from the study completely.

If you are not comfortable with continuing the interview, you may choose to stop the interview at anytime or may withdraw from the study completely.

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If you have any concern about your participation as a research subject, you may contact the Director of Research Services at the University of British Columbia at (604) 822-8598.

Consent: I understand my consent to participate in this study is entirely voluntary. I may refuse to participate or withdraw from the study at any time. This does not jeopardize any access to mental health services presently or in the future.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

Printed Name

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**Consent Form for Participants-Version 2011
(Individual Interviews)**

Research Team:

Masters of Science in Nursing Student: Susan Chong, RN, BNSc, BA
Supervisor: Victoria Smye, RN, PhD., Assistant Professor

Background: Research done with Chinese populations in Canada has focused on the elderly and immigrants accessing mental health services. Very little research exists about adult Chinese women and their experiences of accessing mental health services. Your participation in this study will help with this knowledge gap and could potentially influence accessibility of mental health services for Chinese women in a positive light.

Purpose: The purpose is to explore health care provider’s perspective of what facilitates or is problematic to accessing mental health services for Chinese women.

Study Procedures: If you choose to participate in this study, the researcher (Chong) will interview you once or twice for up to 45 minutes at a time. These interviews will take place in location of your choice and scheduled at a convenient time for you.

The interview will be digitally recorded. The focus of the interviews will be on health care provider’s perspectives of what facilitates or is problematic of access to mental health services for Chinese women.

Risks: You may feel tired thinking or talking about your experiences. If you do become tired, you may choose to stop the interview at anytime or may withdraw from the study completely.

If you are not comfortable with continuing the interview, you may choose to stop the interview at anytime or may withdraw from the study completely.

Privacy and Confidentiality

By participating in the study, all information obtained from you will remain anonymous, where no identifying information will appear in any document about this research. All documents and interview recordings will be identified by a code number and kept in a locked filing cabinet in a locked office. The recordings from the interviews will be stored in a computer that is password protected. These recordings will only be accessible to the researchers.

Contact: If you have any questions or want further information about this study, you may contact Susan Chong at (xxx) xxx-xxxx or her supervisor Victoria Smye at (xxx) xxx-xxxx.

If you have any concern about your participation as a research subject, you may contact the Director of Research Services at the University of British Columbia at (604) 822-8598.

Consent: I understand my consent to participate in this study is entirely voluntary. I may refuse to participate or withdraw from the study at any time.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

Printed Name

Participant Signature

Date

Appendix B: Demographics of Participants

Table 1 Demographics of Chinese Women Participants

Participant	Age	Marital Status	Diagnosis	Types of mental health care accessed
A	28	Single	Bipolar disorder	Hospital, GP, mental health team
B	35	Single	Schizophrenia	Hospital, GP, mental health team
C	41	Single	Bipolar disorder	Hospital, Outpatient department at a hospital
D	30	Married	Bipolar disorder	Hospital, mental health team
E	39	Single	Bipolar disorder later changed to Adjustment Disorder	Hospital, mental health team, GP
F	38	Single	Depression with psychotic features	Hospital, mental health team
G	57	Divorced	Schizoaffective disorder	Hospital, mental health team, GP

Table 2 Demographics of non-Chinese Women Participants

Participant	Age	Marital Status	Diagnosis	Types of mental health care accessed
H	60	Single	Bipolar I	Hospital, GP, mental health team, outpatient department at hospital
I	55	Single	Bipolar I	Hospital, mental health team

Table 3 Demographics of Health Care Providers

Participant	Age	Professional Designation	Number of years working in mental health care settings
J	33	Registered Nurse	four
K	70	Registered Nurse	13

Appendix C : Example Trigger Questions

Participant Interviews:

A) Chinese women and non-Chinese women

- How would you describe your own “mental health”?
- How were you informed of mental health services that exist in your community?
- What was your first contact with mental health services?
- If someone has problems with their mental health, where can they seek help?
- What is helpful about mental health services currently being offered?
- What is not helpful about mental health services currently being offered?
- What other services do you think should be offered for women with mental health issues?
- Do you think mental health service needs between men and women differ?
- Do you think your culture plays a role in access to mental health services?
- Would you consider seeking care elsewhere?

B) Health Care Providers

- How are people informed of mental health services that exist?
- What facilitates access for people who seeking help with their mental health?
- What barriers do people face when trying to access mental health services?
- In your clinical practice, are Chinese women seeking help for their mental health? If not, why?
- What is helpful about mental health services being offered?
- What is not helpful about mental health services being offered?
- Does culture (generally speaking) play in a role in women accessing mental health services?
- Does Chinese culture play in a role in women accessing mental health services?
- What are unique features health providers should know about women when providing care?
- What are unique features health providers should know about Chinese women when providing care?